1972 Amendment Summary

. . . . a summary of the Social Security Amendments of 1972 as they relate to titles II and XVIII of the Social Security Act

U.S. Department of Health, Education, and Welfare
Social Security Administration

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INTRODUCTION

Contents and Organization

This Summary is based on the retirement, survivors, disability, and health insurance provisions of H.R. 1, the Social Security Amendments of 1972. It is issued as an aid in acquainting SSA personnel with these provisions. No attempt has been made to include legal or policy interpretations or implementation, although some rationale has been included as background for the provisions.

Part I of this Summary is set up in sections corresponding to the Claims Manual chapters most affected. Where a single provision of the amendments has considerable impact on more than one CM chapter, it may be stated in full in both of the appropriate sections of the Summary, or the sections may be cross-referred, or a single section of the Summary may cover more than one CM chapter.

Part II of the Summary covers all the amendments to the health insurance program.

Dates

The date of enactment of H.R. 1 is the date the President signs the bill into law. In the interest of earliest possible distribution, this Summary was sent to the printer before the President signed the bill, and thus before the date of enactment and Public Law number of the amendments were known. Where the effective date of a provision is shown as date of enactment, this is the month in which the President signed the bill.

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175. RETIREMENT INSURANCE BENEFITS

Delayed Retirement Credit

The monthly benefit amount is increased by 1/12 of 1 percent for each month in which a fully insured WE is between ages 65 and 72 and is entitled to an unreduced RIB and was either not entitled or did not receive benefits because he was placed in full work deduction status. The increase is applicable for months beginning with the month the WE becomes age 65 up to the month of attainment of age 72. It cannot be applied to a RIB derived from a special minimum PIA.

This credit is effective for increasing RIB's for each year beginning with 1972, and the total so determined shall be applicable to such individual's RIB beginning with benefits for January of the year following the year for which determination is made; except that the total number applicable in the case of an individual who attains age 72 after 1972 shall be determined through the month before the month in which he attains age 72 and shall be applicable to his RIB beginning with the month he attains age 72. (See section 4300 of this Summary for discussion of redetermination of benefits and effect on family maximum.)

Purpose

The delayed retirement credit provides a return in the form of increased benefits to the people who do not get benefits because they continue working between ages 65 and 72--people who pay additional contributions during those years and who may receive no increase in their PIA because of their work between ages 65 and 72.

200. WIFE'S BENEFITS

Requirements for Entitlement of a Divorced wife

The amendments eliminate the support or contributions requirement. This provision is effective for benefits payable beginning 1/73, based on an application filed on or after the date of enactment.

Purpose

The intent of providing benefits for divorced women is to protect women whose marriages are dissolved when they are far along in years--particularly housewives who have not been able to work and earn social security protection of their own--from the loss of current or future benefits. The support requirements in prior law deprived some divorced women of the protection they should have received because in some States courts are prohibited from providing for alimony, or because at the time of divorce the court concluded the wife was not in need of financial support, or because the woman--acting on advice she received at the time of her divorce--accepted a property settlement in lieu of alimony.

With respect to a surviving divorced mother, benefits are provided for her if she is maintaining a home for their child, even though the W/E's circumstances prevented him from furnishing such support before his death.

300. CHILD'S BENEFITS

A. Summary of Significant Changes

The 1972 amendments make the following changes in the provisions of the law relating to child's benefits.

1. A grandchild of the WE or his spouse can qualify as a child of the WE if certain conditions are met.

2. The 1972 amendments provide for uniform requirements for establishing the dependency of a child adopted after the WE's entitlement to an RIB or DIB and eliminate the provision involving a child-placement agency in DIB cases (see section 2650 B. of this Summary for an explanation of this provision).

3. The duration of relationship requirement for a stepchild of a deceased WE has been changed in cases involving the remarriage of the child's natural parent and stepparent and in cases involving accidental death.

4. A child who is a full-time student at age 22 may be initially entitled, or continue to be entitled, to student's benefits for some months after the month in which he attains age 22.

5. A child who is under a disability which began before age 22 (rather than before age 18) may qualify for child's benefits.

B. Dependent Grandchild

1. A dependent grandchild or stepgrandchild of the WE or his spouse may qualify for a child's benefit on the WE's E/R if:

   a. The grandchild's natural or adoptive parents were deceased or disabled:

      (1) At the time the WE became entitled to RIB, DIB, or died; or

      (2) At the beginning of the WE's period of disability which continued until entitlement to RIB or DIB or until his death; or

   b. The grandchild was legally adopted by the WE's surviving spouse in an adoption decreed by a court of competent jurisdiction within the U.S., and the grandchild's natural or adopting parent or stepparent was not living in the household and making regular contributions to the child's support at the time the WE died.

2. A grandchild who meets the requirements of 1.a. or b. above must also meet certain dependency requirements. See section 2650 A. of this Summary for a discussion of these requirements.

3. This provision is effective for benefits beginning 1/73 based on an application filed on or after date of enactment .

Purpose

There are a significant number of children whose parents are deceased or severely disabled and who are cared for and supported by a grandparent. It seems reasonable and equitable to provide benefits for a a child in such cases when his grandparent retires, becomes disabled, or dies. Moreover, even where the child's parents are not deceased or disabled, a less restrictive test than that applied to other children adopted by a surviving spouse should be applicable when the child seeks to qualify on a grandparent's account.

C. Child Adopted After the WE's Entitlement

1. The 1972 amendments provide for uniform requirements for establishing the dependency of a child adopted after the WE's entitlement to an RIB or DIB and eliminate the provision involving a child-placement agency in DIB cases (see section 2650 B. of this Summary for an explanation of this provision).

2. A child adopted after the WE's entitlement to DIB or RIB who meets the new requirements may qualify for benefits no earlier than month of enactment if the application for benefits is filed after 6th month following enactment . However, if application is filed before the end of 6th month following enactment) benefits may be payable retroactively, but no earlier than 1/68, for any month in which the child would have been entitled had the new requirements then been applicable.

Purpose

The Congress believes some safeguards against abuse of the program through adoption of children solely to qualify them for benefits are appropriate. The amendments provide these safeguards, yet simplify the unnecessarily complex rules under prior law which applied differently to children adopted by old-age beneficiaries and to those adopted by disability beneficiaries.

D. Stepchild of Deceased WE--Duration of Relationship Requirement

1. The 9-Month Relationship Requirement

The 9-month duration-of-relationship requirement to establish entitlement as a surviving stepchild, mother, widow, or widower has been modified to permit the claimant to satisfy this requirement, even though the WE dies within the 9-month period if the stepchild, mother, widow, or widower had the necessary relationship to the WE for at least 9 months as a result of a previous marriage which ended in divorce.

Purpose

In most cases, the duration-of-relationship requirement--designed as a general precaution against paying benefits where a marriage is undertaken primarily to secure benefit rights--has worked satisfactorily. However, application of the requirement defeated the basic purpose of paying benefits in cases where a worker and his spouse who were married long enough to meet the requirement were divorced and then remarried shortly before the worker's death. In such situations it is reasonable to consider the duration of relationship requirement to be met, provided it can be established that, at the time of the remarriage, the worker could have been expected to live for at least 9 months.

2. The 3-Month Relationship Requirement

The amendments eliminate the existing 3-month duration-of-marriage requirement for a surviving stepchild, mother, widow, or widower if the WE's death was accidental or occurred in the line of duty while serving on active duty as a member of a uniformed service.

Purpose

The duration-of-relationship requirement in the law serves as a general precaution against payment of benefits when a marriage is undertaken solely to secure benefit rights. The prior law 3-month duration requirement regarding workers whose deaths are due to accidents or occur while serving on active duty in the uniformed services in the line of duty has seemed inappropriate, since such deaths cannot reasonably be forseen at the time of a marriage. However, the requirement that such a worker must otherwise have been expected to live for at least 9 months is a reasonable one and is retained under the amendments.

3. Effective Date

These provisions are effective for benefits payable beginning 1/73 based on an application filed in or after the month of enactment.

E. Entitlement of a Full-Time Student After Age 22

1. The 1972 amendments modify the provisions that benefits are not payable to a student after he has attained age 22. Generally, where a student is in full-time attendance and has not completed the requirements for or received an undergraduate degree in the month of attainment, his entitlement will not terminate until the month after the month in which the quarter or semester ends. If the school does not operate on a quarter or a semester system, the student's entitlement will continue through the month in which the course of study ends or until the third month after the month in which he attains age 22, whichever occurs first.

2. Similarly, a child may become entitled under these conditions to benefits as a full-time student beginning with a month after attainment of age 22 if he is then in full-time attendance.

3. Payments to a student in full-time attendance for any month in or after which he has already attained age 22 may not be made before 1/73.

Purpose

Paying benefits until the completion of the school term relieves the unnecessary hardship that resulted under prior law when benefits were terminated in the middle of a school term.

F. Entitlement of Child Disabled Before Age 22

1. A child disabled before he attains age 22, rather than before age 18, may qualify for benefits on the account of a retired, disabled, or deceased WE.

2. Benefits to a child disabled before age 22 (but not before age 18) are payable for months beginning 1/73. Where the child was not entitled for 12/72 such benefits are payable only on the basis of an application filed after 9/72.

Purpose

In many cases, the period of a child's dependency on the wage earner is extended beyond age 18 because the child spends additional years in school and does not have regular earnings before his twenties. Providing childhood disability benefits for a child who becomes totally disabled before age 22 recognizes this longer period of dependency.

G. Amount of Benefits

1. Beneficiaries who are entitled to benefits on an individual's E/R in 12/72 based on an application filed in or before 12/72 will not have the amount of their benefits reduced for months after 12/72 due to the entitlement of a disabled child based on these amendments.

2. However, these same benefits are not protected from a reduction in amount (if the family maximum applies) due to the entitlement or reentitlement of a child as a dependent grandchild, adopted child, child previously terminated due to adoption, or a student over age 22 based on these amendments.

3. The 1972 amendments provide that a child who is entitled on more than one E/R can be paid benefits based on the E/R which will result in the highest benefit (even if such E/R has a PIA lower than the PIA for another E/R). However, the child can be paid on an E/R other than the E/R with the highest PIA only if such payment would not reduce the benefit amount of any person who is entitled on any of the E/R's involved.

Purpose

Under prior law the benefits for a child entitled on more than one E/R were computed on the record with the highest PIA. This did not always result in paying the child the highest potential benefit amount because benefits for surviving children are 75 percent of the PIA, while benefits for children of retired or disabled workers are 50 percent of the PIA. The new provision is more equitable to children who may be entitled to benefits on more than one E/R.

H. Deductions

If a disabled child who has attained age 55 is disabled solely by reason of the special definition (Section 223(d)(1)(B) of the Act) that applies to blind persons age 55 and over, benefits are not payable for any month in which he engages in SGA.

I. Termination of Entitlement

1. Prior to the 1972 amendments, benefits of an entitled child were terminated if the child was adopted by certain close relatives after the WE's death. These amendments provide that, beginning with the month of enactment, a child's benefits will not terminate regardless of who adopts the child or whether the adoption occurred before or after the WE's death.

In many cases, a surviving child is adopted by an unrelated person or by a relative more distant than one specified in prior law (a stepparent, grandparent, aunt, uncle, brother or sister). Since the adoption generally is undertaken to secure for the child the legal and psychological advantages of adoption within a close family group, it seemed inappropriate to weaken the child's financial situation by depriving him of his social security benefits. The change in the law provides for continuing the payment of benefits to an entitled child who is adopted, regardless of who adopts him, thereby also eliminating the possibility that some people might postpone or cancel plans for adoption due to a prospective loss of benefits.

2. Benefits based on a disability which began between the ages of 18 and 22 will terminate the third month following the month in which the child ceases to be under a disability, or (if later) the earlier of (1) the first month during no part of which he is a full-time student, or (2) the month in which he attains age 22 (as modified by E above).

3. The benefits of a child who is in full-time attendance at the time he attains age 22 may not terminate until the month after the month in which the quarter or semester ends if the conditions explained in E.1. above are met.

J. Requirements for Reentitlement

The 1972 amendments provide that a child whose entitlement to child's benefits was terminated, and who has not been married since his last entitlement, may be reentitled upon the filing of an application on the basis of:

1. A disability which began before age 22; or

2. A disability which began before the close of the 84th month following the month in which his most recent entitlement to child's benefits terminated because his disability ceased; or

3. Prior entitlement which was terminated because of adoption.

Purpose

Permitting reentitlement to childhood disability benefits within 7 years affords a former childhood disability beneficiary an opportunity to work long enough to gain disability protection as a worker. This change is consistent with present-law provisions which permit disabled widows and disabled dependent widowers to become reentitled to benefits if they again become disabled within 7 years after recovering from an earlier disability.

Where the adopted child was not entitled for month prior to month of enactment benefits may not begin again before month after month of enactment based on an application filed after date of enactment .

K. Entitlement to Medicare for Disabled Children

The 1972 amendments provide that children entitled based on disability, who have been entitled to these benefits for 24 consecutive calendar months, shall be entitled to hospital insurance benefits. Entitlement to such benefits begins with the 25th consecutive month of entitlement (but no earlier than 7/73). The disabled child is also eligible to enroll in the supplementary medical insurance program at the same time.

Purpose

In general, disabled beneficiaries have medical needs in excess of the aged, and far in excess of the rest of the population. For example, studies indicate that DI beneficiaries use about seven times as much hospital care and three times as many physicians' services as does the nondisabled population. In comparison with those who are not disabled, they have limited incomes and are financially unable to buy adequate private health insurance, or to obtain such insurance at all.

Requiring a person to have been entitled to disability benefits for at least 2 years provides necessary protection and at the same time holds program costs within reasonable bounds, avoids possible overlapping of Medicare and private health insurance protection (particularly where a disabled person can continue his membership in a group insurance plan for a period of time following the onset of his disability) and minimizes administrative problems that otherwise would arise in cases where the final decision regarding entitlement to disability benefits is not reached until some time after application is made because of appeals processing.

A. Widow Defined

1. Duration of Marriage in Case of Remarriage to Same Individual

The 1972 amendments provide that in the case of a widow who married, divorced, and remarried the same individual, the duration-of-marriage requirement will be satisfied if such requirement would have been met at the time of the divorce if the marriage had been terminated by the WE's death instead of the divorce.

Purpose

See section 300 D.1. of this Summary for purpose of this provision.

2. Duration of Marriage Where Death Was Accidental

The 1972 amendments eliminate the existing 3 month duration-of-marriage requirement where the WE's death was accidental or occurred in line of duty as a member of a uniformed service.

Purpose

See section 300 D.2. of this Summary for purpose of this provision.

3. Effective Date

The changes in 1. and 2. above are effective for benefits payable for months beginning 1/73, based on applications filed in or after the month of enactment.

B. Requirements for Entitlement

1. Widow--Application

Wife's or mother's benefits will no longer be converted to widow's benefits if the beneficiary is under age 65. An application for reduced widow's benefits will now be required by women under age 65 except for a woman who was entitled to wife's benefits for the month before the WE's month of death, and is not entitled to a RIB or DIB based on her own earnings.

2. Surviving Divorced Wife

A surviving divorced wife will no longer need to meet a support requirement. This change is effective for benefits payable for months beginning 1/73, based on applications filed on or after the date of enactment.

Purpose

See section 200 of this Summary for purpose of this provision.

3. Disability Requirements

The required waiting period for a disabled widow or surviving divorced wife is reduced to 5 months instead of the 6 months required by present law. The earliest beginning date of the waiting period is also shortened by 1 month. This provision is effective 1/73 on the basis of an application filed in or after month of enactment or for applications filed before month of enactment if no final determination has been made by month of enactment .

Purpose

See section 6000 D. of this Summary for purpose of this provision.

C. Amount of Widow's Benefit

The 1972 amendments provide that a widow or surviving divorced wife who becomes entitled in or after the month she attains age 65 will receive a benefit equal to the deceased WE's PIA. If, however, the WE at any time received a reduced benefit, the widow's benefit may also be reduced. See section 4300 of this Summary for discussion of this provision and for:

1. Changes in provisions concerning amount of widow's or surviving divorced wife's benefits where initial entitlement begins before age 65; and

2. Provisions for the redetermination of benefit rates for widows or surviving divorced wives in benefit status for 12/72 as if the 1972 amendment provisions had been in effect in the first month of their entitlement.

These provisions are effective for benefits payable for months beginning 1/73.

Purpose

See section 4300 B. of this Summary for purpose of this provision.

D. Entitlement to Medicare for Disabled Widows

The 1972 amendments provide that disabled widows who have been entitled to these benefits for 24 consecutive calendar months shall be entitled to hospital insurance benefits. Entitlement to such benefits begins with the 25th consecutive month of her entitlement (but no earlier than 7/73). The disabled widow is also eligible to enroll in the supplementary medical insurance program at the same time. Entitlement to medicare ends with the month following the month in which notice of termination of her entitlement to disabled widow's benefits is mailed to her.

Purpose

See section 300 K. of this Summary for purpose of this provision.

450. WIDOWER'S BENEFITS

A. Widower Defined

1. Duration of Marriage in Case of Remarriage to Same Individual

The 1972 amendments provide that in the case of a widower who married, divorced, and remarried the same individual, the duration-of-marriage requirement will be satisfied if such requirement would have been met at the time of the divorce if the marriage had been terminated by the WE's death instead of the divorce.

Purpose

See section 300 D.1. of this Summary for purpose of this provision.

2. Duration of Marriage Where Death was Accidental

The 1972 amendments eliminate the existing 3-month duration-of-marriage requirement where the WE's death was accidental or occurred in line of duty as a member of a uniformed service.

Purpose

See section 300 D.2. of this Summary for purpose of this provision.

3. Effective Date

These changes are effective for benefits payable for months beginning 1/73, based on applications filed in or after the month of enactment.

B. Requirements for Entitlement

1. Age

A benefit may be paid to a widower if he has attained age 60 (rather than age 62) even though not under a disability.

Purpose

Since September 1965, widows who are not disabled could become eligible for reduced benefits at age 60. To provide the same option for men, the new law also lowers the age of eligibility for dependent widowers from 62 to 60.

2. Application

Generally, a man under age 65 must now file an application for widower's benefits regardless of his previous entitlement to husband's benefits. An exception to this is the case of a man under age 65, who was entitled to husband's benefits in the month before the WE's death, and is not entitled to a RIB or DIB based on his own earnings. This change is effective 1/73.

3. Remarriage

Since a widower may now become entitled at age 60, instead of age 62, the age at which remarriage is no bar to entitlement or reentitlement is also reduced to age 60, instead of age 62.

4. Disability Requirements

The required waiting period for a disabled widower is reduced to 5 months instead of the 6 months required by present law. The earliest beginning date of the waiting period is also shortened by 1 month.

The effective date for these provisions is 1/73. Where a widower was not entitled for 12/72, the changes with respect to age (B1 and B3) are effective only on the basis of an application filed in or after month of enactment. The reduction of the waiting period (B4) is effective for applications filed in or after month of enactment or for applications filed previously if no final determination made by month of enactment.

Purpose

See section 6000 D. of this Summary for purpose of this provision.

C. Amount of Benefit

1. Benefit Rate

The 1972 amendments provide that a widower who becomes entitled in or after the month he attains age 65 will receive a benefit equal to the deceased WE's PIA. If, however, the WE at any time received a reduced benefit, the widower's benefit may also be reduced. See section 4300 of this Summary for discussion of this provision and for:

a. Changes in provisions concerning amount of widower's benefit where initial entitlement begins before age 65; and

b. Provisions for the redetermination of benefit rates effective 1/73 for widowers in benefit status for 12/72 as if the 1972 amendment provisions had been in effect in the first month of this entitlement.

2. Benefit Amount for Widower Remarried After Attaining Age 60

Effective 1/73 the amount of a widower's benefit upon remarriage after age 60 (except for marriage to a person entitled to widow's, parent's, or childhood disability benefits), is equal to one-half the WE's PIA. Previously, this provision was applicable only to widowers who remarried after age 62.

Purpose

See section 4300 B. of this Summary for purpose of this provision.

D. Termination of Entitlement

A disabled widower's entitlement will end with the third month after the month in which his disability ceases, unless he has attained age 65. Remarriage after attainment of age 60 will not terminate a widower's entitlement.

These changes are effective 1/73.

E. Nonpayment of Benefits

Deductions for refusal without good cause to accept VR service apply to a disabled widower under age 60, instead of under age 62, beginning 1/73.

F. Entitlement to Medicare for Disabled Widowers

The 1972 amendments provide that disabled widowers who have been entitled to these benefits for 24 consecutive calendar months shall be entitled to hospital insurance benefits. Entitlement to such benefits begins with the 25th consecutive month of his entitlement (but no earlier than 7/73). The disabled widower is also eligible to enroll in the supplementary medical insurance program at the same time. Entitlement to Medicare ends with the month following the month in which notice of termination of his entitlement to disabled widower's benefits is mailed to him.

Purpose

See section 300 K. of this Summary for purpose of this provision.

500. MOTHER'S BENEFITS

A. Widow Defined--Duration of Marriage

1. Remarriage to Former Spouse

The 1972 amendments provide that in the case of a widow who married, divorced, and remarried the same individual, the duration-of-marriage requirement will be satisfied if such requirement would have been met at the time of the divorce if the marriage had been terminated by the WE's death instead of the divorce.

Purpose

See section 300 D.1. of this Summary for purpose of this provision.

2. Accidental or Service-Connected Death

The 1972 amendments eliminate the existing 3-month duration-of-marriage requirement in cases where the WE's death was accidental or occurred in the line of duty while serving on active duty as a member of a uniformed service.

Purpose

See section 300 D.2. of this Summary for purpose of this provision.

These changes are effective for benefits payable for months beginning 1/73, based on applications filed in or after the month of enactment.

B. Requirements for Entitlement--Surviving Divorced Mother

The 1972 amendments eliminate the support or contributions requirement. The other requirements for entitlement are unchanged.

This change is effective for benefits payable beginning 1/73, based on applications filed on or after the date of enactment.

Purpose

See section 200 of this Summary for purpose of this provision.

C. Health Insurance for Mothers

A claimant entitled to disabled widow's benefits will qualify for health insurance benefits beginning with the 25th month of her entitlement to such benefits (but no earlier than 7/73). To permit a mother, who meets all of the requirements for disabled widow's benefits (except for the filing of an application for such benefits), to qualify for Medicare protection as soon as possible the law contains a special provision. Where such a mother establishes her entitlement to disabled widow's benefits before 7/1/74, she will, for the purpose of determining when her entitlement to Medicare begins, be deemed to have become entitled to disabled widow's benefits in the first month in which she could have been entitled had she filed.

Purpose

See section 300 K. of this Summary for purpose of this provision.

1100. WAGES

A. Changes in Social Security Contribution Rates

The rates of employee and employer contributions applicable to wages for both the RSDI and health insurance (HI) programs are changed beginning with 1973. Below is a table showing the current and revised rates.

Wages Received During Calendar Years	RSDI Rate (Percent)	HI Rate (Percent)	Combined Rate (Percent)
1972	4.60	.60	5.20
1973 - 1977	4.85	1.00	5.85
1978 - 1980	4.80	1.25	6.05
1981 - 1985	4.80	1.35	6.15
1986 - 2010	4.80	1.45	6.25
2011 and after	5.85	1.45	7.30

B. Deemed Military Wages After 1956

Under the amendments, the amount of deemed military wages creditable for a serviceman is changed to $300 for calendar quarters after 1956 in which he was paid wages (basic pay for active duty or active duty for training) in any amount. The amendment is effective with respect to monthly benefits payable after December 1972 and LSDP involving deaths after 1972. See sec. 1800 of Summary for full explanation.

C. Wages Paid After Age 62 - Nonwork Periods

Under the amendments, the age provision for men with respect to payments for nonwork periods is changed from age 65 to 62. Thus, a payment (other than vacation or sick pay) made to either a man or woman after the month in which the employee attains age 62 is excluded from wages if the employee did not do any work for the employer in the period for which such payment is made. This change will apply only with respect to payments made after 1974.

Purpose

Changing the ending point from 65 to 62 in determining the exclusion from wages for nonwork periods for men eliminates differences in the way these provisions apply to men and women--differences which, upon review, seem unwarranted.

D. Payments by Employer to Survivor or Estate of Former Employee

Under the amendments, payments made after December 1972 by an employer to a survivor or to the estate of a former employee after the calendar year in which such employee died do not constitute wages for social security purposes and the payments will not be subject to FICA taxes.

Purpose

This provision is intended to exclude from coverage payments, particularly life insurance renewal commissions, made to an employee's estate or survivor after the year the employee died since these payments cannot be used to meet eligibility requirements or to increase the amount of social security benefits.

E. Deemed Wages for Certain Interned Individuals

The amendments provide deemed wage credits for U.S. citizens who were interned by the U.S. Government during any part of the period from December 7, 1941, through December 31, 1946. (See section 4300 of this Summary for a complete discussion of this provision).

F. Payments by Employer to Disabled Former Employee

The amendments except from the definition of wages any payments made by an employer to an employee after the calendar year in which the employee became entitled to social security disability benefits, if the employee did not perform any services for that employer during the period for which payment is made.

Payments by an employer to a disabled former employee made after December 1972 would be excluded from wages and would not be subject to FICA taxes.

Purpose

The intent of this new provision is to treat such payments in the same manner as those amounts which are paid after the year of the WE's death to his survivors or his estate.

1300. COVERAGE AND EXCEPTIONS

A. Members of Religious Orders Who Have Taken a Vow-of-Poverty

The 1972 amendments provide that a religious order (any autono mous subdivision thereof) whose members must take a vow-of-poverty may elect to have social security coverage for members performing services in the exercise of duties required by the order (or such subdivision) by filing a certificate with the Internal Revenue Service. The election is irrevocable. The members have no choice in the matter. They are automatically covered under the certificate of election provided they meet the definition of "member."

Effective Date: The provision is effective upon enactment.

Purpose

This amendment gives recognition to the desire of the orders for social security coverage and the approach reflects the special problems in providing coverage for such members.

B. Employees of Federal Home Loan Banks

The amendments extend coverage to services performed in the employ of a Federal Home Loan Bank beginning on or after January 1, 1973.

Persons who are employees of a Federal Home Loan Bank on or after January 1, 1973, would also have any services they performed in the employ of any such Bank after 1966 covered if the social security contributions (FICA taxes) on earnings for such services are paid by July 1, 1973, or later if agreed on before July 1, 1973, with the Secretary of the Treasury.

Purpose

The Federal Home Loan Banks requested that coverage be extended to the employees of the banks (about 500). These employees are now covered under the Savings Association Retirement Fund which is coordinated with social security; employees of about 370 Federal savings and loan banks are covered under both this retirement system and social security.

C. Employees of the Government of Guam

Services performed by an employee of the Government of Guam, properly classified as a temporary or intermittent employee, are compulsorily covered under social security if such services are not covered by a retirement system established by a law of Guam. This amendment provision does not apply to services performed:

a. By an elected official; or

b. By a member of the legislature; or

c. In a hospital or penal institution by a patient or inmate thereof.

This provision is effective for services performed on or after January 1, 1973.

Purpose

This provision extends social security coverage to about 1,500 employees of the Government of Guam; under prior law these employees generally had no retirement, survivor, or disability protection because they were excluded from coverage under the retirement system for employees of the Government of Guam.

Students Employed by Nonprofit Auxiliary Organizations of Schools, Colleges, and Universities

The 1972 amendments except from employment services performed by a student in the employ of any nonprofit auxiliary organization of a school, college, or university where he is enrolled and regularly attending classes if the auxiliary organization is organized and operated exclusively for the benefit of, and supervised, or controlled by such school, college, or university.

Prior to the 1972 amendments, services performed by a student for a nonprofit auxiliary organization of a school, college, or university where he was enrolled and regularly attending classes were covered (if his remuneration for such services were $50 or more in a quarter) even though services by the student for the school were excepted.

This exception from employment does not apply to services for an auxiliary organization of a school, college, or university of a State or political subdivision if the services for such school, college, or university are covered under an agreement between the Secretary of Health, Education, and Welfare and such State entered into pursuant to section 218 of the act.

The exception applies to services performed after December 31, 1972.

Purpose

This amendment eliminates situations in which students working for a school where they were enrolled and regularly attending classes were not covered under social security while other students working for nonprofit organizations auxiliary to the school where they were enrolled and regularly attending classes were covered.

A. Coverage of Firemen's and Policemen's Positions under a Retirement System--Idaho

Effective upon enactment, the State of Idaho is added to the list of States which may cover the services of employees in firemen's and policemen's positions which are under a retirement system.

B. Coverage of Certain Hospital Employees in New Mexico

Effective upon enactment, the State of New Mexico is authorized, if it so chooses, to modify its agreement at any time prior to February 1, 1973, to provide coverage (as a separate coverage group) for services of employees of a hospital which is an integral part of a political subdivision for which coverage had not been previously provided. The hospital, prior to 1966, must have withdrawn from a retirement system which had been applicable to the employees of the hospital.

Purpose

Through a misunderstanding within the State of New Mexico, certain hospital employees who were covered under a State retirement system were removed from that system with the expectation of then obtaining social security coverage. However, this short period of retirement system coverage, unintended as far as the hospital and the employees were concerned, prevented the employees from obtaining social security coverage. This amendment is designed to permit these hospital employees to be covered under social security.

C. Termination of Coverage of Registrars of Voters--Louisiana

Effective upon enactment, the Secretary is authorized to permit the State of Louisiana to modify its coverage agreement entered into under section 218 of such act so as to terminate the coverage of all employees in positions under the Registrars of Voters Employees' Retirement System effective after December 1975, but only if the State files with the Secretary notice of said termination on or before December 31, 1973. If the coverage of such employees is terminated pursuant to the above, coverage cannot later be extended to employees in positions under the Registrars of Voters Employees' Retirement System.

D. Modification of State Agreements with Respect to Certain Students and Certain Part-Time Employees

Effective upon enactment, any State may, at any time prior to January 1, 1974, modify its coverage agreement so as to exclude services in any class or classes of part-time positions and/or services performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university.

The exclusion will be effective after the calendar quarter following the quarter in which the agreement is modified. If coverage is excluded under this provision, it cannot again be provided.

Purpose

States that did not exercise their option to exclude from coverage the services of such employees at the time coverage was extended to a coverage group may now have reasons for excluding them. This provision permits the States to exclude the services of such employees without terminating the coverage of other State and local employees in the same coverage group.

E. Modification of Agreement with West Virginia to Provide Coverage for Certain Policemen and Firemen

Effective upon enactment, the State of West Virginia is authorized to modify its coverage agreement so as to provide retroactive and prospective coverage pursuant to subsection 218(c)(4), for services performed in policemen's or firemen's positions covered by a retirement system, as employees of any class III or class IV municipal corporation (as defined in or under the laws of the State) if the State of West Virginia has at any time prior to the date of enactment paid to the Secretary of the Treasury the contributions prescribed by section 218(e)(1) of the act regarding the services performed by the employees.

Purpose

Certain policemen and firemen in positions subject to a retirement system in West Virginia were mistakenly thought to be covered under social security and their wages were erroneously reported. The purpose of the provision is to permit the State to validate the past reports and to provide continuing social security coverage of the positions involved.

1500. SELF-EMPLOYMENT

A. Optional Method of Computing Nonfarm NE from SE

An individual whose gross income from a trade or business in which the major part of the services would not constitute agricultural labor if performed by employees may use for his taxable year the optional method of computing NE from SE provided his actual nonfarm NE from SE together with his actual or optional farm NE from SE are less than $1,600 and less than 2/3 of his gross nonfarm and farm income. This nonfarm option can be used only if he had actual NE from SE of not less than $400 from all his trades or businesses in each of at least 2 of the 3 immediately preceding taxable years. The nonfarm optional method cannot be used for more than 5 taxable years. Where both options (nonfarm and farm) are utilized in computing NE from SE the maximum amount of NE from SE cannot exceed $1,600.

This provision is effective for taxable years beginning after 1972.

Purpose

This option is designed to give operators of nonfarm businesses social security protection similar to that available to farm operators in years when they have small net earnings or suffer net losses, thus enabling them to maintain continuity of social security coverage.

B. Coverage of U.S. Citizens Who Retain Residence in the United States While Self-Employed Outside the United States

The amendments provide that an individual who has been a resident of the U.S. during the entire taxable year shall compute his net earnings from self-employment without regard to the exclusion from gross income provided by Section 911(a)(2) of the Internal Revenue Code of 1954. Under this provision, earnings from self-employment derived by a U.S. citizen outside the U.S. who retains his residence in the U.S. throughout the entire taxable year is includible in gross income for computing net earnings from self-employment even though such earnings may be excluded for income tax purposes.

This provision is effective for taxable years beginning after 1972.

Purpose

This change provides coverage for some self-employed U.S. citizens--e.g., free-lance newspapermen or news commentators--who work outside the United States for long periods at a time before returning to the United States. Because under prior law such citizens were required to exclude earned income up to $20,000 a year for social security purposes, their social security protection was often adversely affected through interruption or reduction of their social security coverage.

C. Changes in Self-Employment Contribution Schedule

The amendments provide for the following contribution rates on self-employment income for retirement, survivors, disability insurance and hospital insurance purposes:

Taxable Year Begins	RSDI Rate (Percent)	Hospital Insurance Rate (Percent)	Combined Rate (Percent)
In or after 1973	7.0	1.0	8.0
In or after 1978	7.0	1.25	8.25
In or after 1981	7.0	1.35	8.35
In or after 1986	7.0	1.45	8.45

D. U.S. Citizen Ministers and Members of Religious Orders Serving Outside the United States

The amendments provide that U.S. citizen ministers and members of religious orders serving abroad shall compute their net earnings from self-employment in the same manner as if they were serving in the United States, i.e., without regard to foreign and possession income exclusions. The amendments remove the present requirement that a minister or member of a religious order serving abroad must be an employee of an American employer or serve a congregation composed predominantly of U.S. citizens in order to compute NE from SE without the foreign and possession income exclusions.

This provision is effective for taxable years beginning after 1972.

Purpose

This change is designed to improve social security protection for ministers and members of religious orders who are U.S. citizens but who are not residents of the United States by providing that they shall compute their income for social security purposes without regard to the $20,000 foreign and possession earned-income exclusion. Because most such ministers and members of orders do not earn as much as $20,000 a year, they were in effect being excluded from coverage under prior law.

1800. VETERANS' BENEFITS

A. Deemed Military Wages for Active Military Service after 1956

The amendments provide that members of the uniformed services will receive credit for deemed military wages in the amount of $300 per quarter for calendar quarters after December 1956 in addition to the basic wage paid for that service. This provision replaces the deemed military wages previously granted in amounts of $100, $200, or $300 for MS after 1967.

B. Effective Date

This provision is effective for monthly benefits payable for months after December 1972; and with respect to lump sum death payments for deaths occurring after 1972. Individuals entitled to benefits for the month of enactment must file a request for a recalculation in order to have the new deemed wages considered. The first month for which the recalculated benefit can become payable is January 1973 or, if later, the twelfth month before the month in which it is filed.

C. Developing Military Service for the Special Minimum PIA Provision

Gratuitous MS wage credits for active MS prior to 1957 are included as earnings for purposes of developing a year of coverage to compute benefits under the special minimum PIA provision. See section 4300 A of this Summary for information about the special minimum PIA.

Purpose

Under prior legislation, additional wage credits were granted beginning with 1968 to take account of the fact that only basic pay is covered under social security on a contributory basis while servicemen receive other cash payments and wages in kind which are generally counted as wages in the case of other jobs covered under social security. This change would provide the wage credits beginning with 1957, the year in which contributory coverage of servicemen started.

. Dependency Requirements--Grandchild or Stepgrandchild

A grandchild or stepgrandchild shall be deemed dependent on the WE provided:

1. The child had been living with the WE in the U.S. and receiving at least one-half of his support from such WE for the year immediately before:

   a. The month in which the WE became entitled to RIB or DIB, or died; or

   b. The month in which the WE's period of disability began if it continued to his entitlement to RIB or DIB or to his death; and

2. The child began living with the WE before he attained age 18.

3. A grandchild or stepgrandchild born during the applicable one-year period, is deemed dependent if:

   a. He lived with the WE in the U.S. for substantially all the period which begins with the child's birth and ends with the applicable month as determined in 1. a. or b. above; and

   b. He received at least one-half support from the WE for substantially all the same period.

This provision is effective for benefits payable 1/73 based on an application filed on or after date of enactment. See section 300 B. of this Summary for explanation of this provision.

. Child Adopted After the WE's Entitlement

The amendments change the requirements for establishing the dependency of a child adopted by a WE after he is entitled to RIB or DIB. Such a child shall be deemed dependent on the WE provided the child:

a. Is the WE's natural child or stepchild; or

b. Was legally adopted by the WE in an adoption decreed by a court of competent jurisdiction in the U.S., and

   (1) Was living with the WE in the U.S. for the applicable year in c. below; and

   (2) Was receiving at least one-half of his support from the WE for such year; and

   (3) Had not attained the age of 18 before he began living with the WE.

c. The year during which the child must have been living with and receiving at least one-half support from the WE is the year immediately before:

(1) The month in which the WE became entitled to RIB (but only if the WE was not entitled to DIB for the preceding month); or

(2) The month in which the WE became entitled to DIB; or

(3) The month in which the WE's period of disability began, which existed at the time of the adoption (or if the child is adopted after the WE attains age 65, the month the period of disability began which existed in the month before attainment).

d. An adopted child born during the applicable one-year period is deemed to meet the living-with and one-half support requirement if:

(1) The child lived with the WE in the U.S. for substantially all the period which begins with the child's birth and ends with the applicable month as determined in c. above; and

(2) He received at least one-half support from the WE for substantially all the same period as indicated in c. above.

This provision is effective for benefits payable beginning 1/68 if an application is filed before the close of the sixth month after the month of enactment; otherwise the provision is effective for benefits payable beginning month of enactment.

PURPOSE

See section 300 C.2. for purpose of this provision.

2800. SOCIAL SECURITY NUMBERS

Method of Issuance of Social Security Account Numbers

The amendments authorize the Secretary to assign numbers to children of preschool age upon request of parent or guardian, and to all children of school age at the time of first enrollment in school. It requires the Secretary to assign numbers to aliens at the time of lawful admission either for permanent residence or under authority of law permitting employment and to individuals who apply for or receive benefits under any program financed in whole or in part from Federal funds.

The amendments provide that social security numbers are to be assigned by the Secretary to those individuals falling within the above groups who have not been assigned numbers but could have been. This will be done provided investigation shows that no numbers have previously been assigned and the person is not prohibited from working in the United States because of alien status.

The amendment provisions require all applicants to submit sufficient evidence to establish age, identity and citizenship status.

Provision is made for agreements to be made with Federal, State and local officials to implement the above provisions.

Effective date: These provisions are effective upon enactment.

4200. INSURED STATUS

FULLY INSURED STATUS

1. Requirements

The 1972 amendments reduce the number of quarters of coverage necessary to qualify a man for fully insured status. Insured status of a male worker will be based on the number of years elapsing after 1950 before the year in which he died or (if earlier) the year in which he attains age 62. This provision will apply only to men who attain age 62 in 1975 or later. Men who attain age 62 in 1973 will have years up to age 64 taken into account, and men who attain age 62 in 1974 will have years up to age 63 taken into account.

2. Effective Date

This provision is effective for monthly benefits for months beginning January 1973.

Purpose

Changing the ending point from 65 to 62 in determining insured status for men eliminates differences in the way these provisions apply to men and women--differences which, upon review, seem unwarranted.

4300. COMPUTATIONS AND RECOMPUTATIONS

A. SPECIAL MINIMUM PIA

1. Requirements for Increase

The 1972 amendments provide for a special minimum PIA which is equal to $8.50 multiplied by the number of the WE's "years of coverage" in excess of 10, if such amount is higher than the PIA as determined under regular computation methods.

For purposes of determining the special minimum PIA, the number of the WE's "years of coverage" (not to exceed 30) is equal to the sum of:

a. The number (not to exceed 14) determined by dividing the total wages credited to him for years after 1936 and before 1951 by $900; plus

b. The number of computation base years after 1950 in which the WE is credited with wages and SEI of not less than 25 percent of the maximum amount creditable for each such year.

2. Family Maximum

The family maximum for each special minimum PIA is the highest of:

a. The maximum shown in the table in the act (i.e., the table maximum); or

b. If the PIA does not appear in the table, the maximum shown for the next higher PIA which does appear in the table; or

c. The highest benefit conversion saving clause maximum which was determined for the WE's account.

3. Effective Date

The provision for the special minimum PIA is effective for monthly benefits payable beginning 1/73 (without regard to when the WE became entitled or when he died) and for LSDP's payable in the case of death occurring after 12/72.

Purpose

The special minimum PIA provision is designed to benefit those individuals who worked for many years in covered employment at very low wages. It is not intended to benefit those who have had only intermittent and casual employment in covered work and who have not relied upon covered employment for their livelihoods. It appears that many, if not most, people receiving the minimum benefit under social security are doing so because they had little connection with covered employment. This can occur when the individual spent most of his working career in, say, the Federal civil service, under a State retirement system not linked to social security, or as a policeman or fireman. A substantial increase in the minimum PIA--based solely on average earnings--thus would go largely to people who have worked only sporadically under social security and who may be receiving substantial benefits from another public pension program.

B. INCREASED WIDOW'S (WIDOWER'S) BENEFITS

1. Deceased WE, on whose E/R the widow's (widower's) entitlement is based, was never entitled to reduced RIB during her (his) lifetime.

a. Widow (Widower) Age 65.--A person who first becomes entitled to a widow's or widower's benefit at or after age 65 will receive a benefit equal to 100 percent of the deceased WE's PIA.

b. Before Age 65.--A person who becomes entitled to a widow's or widower's benefit before age 65 will receive a benefit equal to the PIA reduced by 19/40 of one percent per month for each month of entitlement from age 60 and prior to age 65. At age 62 the benefit will be 82.9 percent of the WE's PIA. At age 60 it will be 71.5 percent of the PIA. (The reduction factor of 19/40 of one percent per month replaces the reduction factor of 5/9 of one percent per month between age 60 and 62.) The additional reduction for (disabled) widows and widowers is changed from 43/198 of one percent per month to 43/240 of one percent per month for each month of entitlement from age 50 up to age 60.

c. Sole Surviving Widow (Widower).--Where there is a sole surviving widow or widower who first becomes entitled at or after age 62 the amount of the benefit cannot be lower than $84.50. Where a sole surviving widow (widower) becomes entitled before age 62 the benefit she (he) will receive can be no less than $84.50 reduced by the number of months of entitlement prior to age 62 (at the regular widow's reduction rate of 19/40 of one percent for each month of entitlement from age 60 and before age 62 and at a reduction rate of 43/240 of one percent for each month of entitlement from age 50 up to age 60).

2. Deceased WE, on whose E/R the widow's (widower's) entitlement is based was entitled to a reduced RIB during his lifetime.

   a. Widow's or widower's benefit reduced under section 1.b. equals or is less than 82½ percent of the PIA.--Where the widow's (widower's) benefit reduced under section 1.b. above equals or is less than 82½ percent of the PIA, the fact that the deceased WE was entitled to a reduced RIB will not be taken into consideration in determining the amount of the widow's (widower's) benefits.

   b. Widow's or widower's benefit reduced under section 1.b. is greater than 82½ percent of the PIA.--Where the widow's (widower's) benefit reduced under section 1.b. above is greater than 82½ percent of the PIA, the fact that the deceased WE on whose E/R the widow (widower) becomes entitled was entitled to reduced benefits will be a factor which must be taken into consideration in determining the amount of the widow's (widower's) benefits.

      In these cases the widow's (widower's) benefit determined under the method described in section 1.b. above cannot exceed the benefit rate to which the deceased WE would have been entitled if he were still living. If this latter benefit rate is lower than the rate described in section 1.b. above the widow (widower) will receive the higher of: (i) 82½ percent of the deceased WE's PIA or (ii) the benefit rate to which the deceased WE would have been entitled if he were still living.

3. Reduction Factor Adjustment

   The reduction factor of a widow will be adjusted at age 62 and again at age 65.

4. Redetermination of Widow's and Widower's Benefit

   a. Where a widow or widower is entitled for December 1972, the benefit amount will be redetermined in order to arrive at a benefit equal to what would have been received had the 1972 amendments been in effect in the first month of widow's (widower's) entitlement.

   b. This redetermination will be effective with respect to monthly benefits after December 1972.

5. Saving Clause

   Beneficiaries entitled for 12/72 on the same E/R as a widow or widower whose benefit is redetermined under the amendment provision will not have their benefits decreased (for 1/73 on) as a result of the redetermination of the widow's or widower's benefit.

6. Effective Date

This provision is effective January 1, 1973.

Purpose

There are several reasons for the increased widow(er) benefits. The expenses of a widow living alone are no less than those of a single retired worker. In addition, surveys of social security beneficiaries have shown that, on the average, women receiving widow's benefits not only get lower benefits but also have less regular income other than social security than most other classes of beneficiaries. Congress believed that aged widows should be paid the amount that would have been paid to their husbands as retired beneficiaries. The reduction in benefits for widows and widowers who come on the rolls between 60 and 65 takes into account the longer period over which the benefits will be paid, just as a worker's benefit is reduced if he takes benefits before age 65.

C. DELAYED RETIREMENT CREDIT

1. Benefit Increase

The amendments provide that an individual's RIB may be increased 1/12 of one percent for each "increment" month if:

a. Initial entitlement to a RIB is at age 65 or later; or

b. If entitlement is before age 65, the RIB, when adjusted at age 65, is no longer reduced for age.

The delayed retirement credit cannot be applied to a RIB derived from a special minimum PIA. The increase in the WE's RIB will in no way affect the family maximum or benefits to auxiliaries.

2. Definition of Increment Month

An increment month is any month (but not earlier than 1/71) in which the WE:

a. Has attained age 65 (but has not attained age 72); and

b. Is fully insured; and

c. (i) Is not entitled to a RIB; or

(ii) If entitled to a RIB, suffered a work deduction equal to his monthly benefit.

3. Computation of Retirement Credit

The total number of a WE's increment months will be determined after the end of each year. The increase (if any) in the WE's RIB is effective with January of the year following the latest year for which the determination was made.

Exception:

If the WE attains age 72 after 1972, increment months for the year of attainment of age 72 will increase the RIB effective with the month in which he attains age 72.

4. Effective Date

The provision applies to RIB's payable for months after 12/72.

Purpose

The delayed retirement credit provides a return in the form of increased benefits to the people who do not get benefits because they continue working between ages 65 and 72--people who pay additional contributions during those years and who may receive no increase in their PIA because of their work between ages 65 and 72.

D. AGE 62 COMPUTATION POINT FOR MEN

1. The 1972 amendments change the ending point for determining elaps years to be used in computing the PIA of a male wage earner.

   a. Elapsed years for men who attain age 62 in 1975 or later are counted up to the year of attainment of age 62 (or, if earlie the year of death).

   b. Elapsed years for men who attain age 62 before 1975 are count up to the earliest of:

      (i) the year of attainment of age 65, or
      (ii) 1975, or
      (iii) the year of death.

2. This provision is effective for benefits payable beginning 1/73.

Purpose

Changing the ending point from 65 to 62 in determining benefit amounts for men eliminates differences in the way these provisions apply to men and women--differences which, upon review, seem unwarranted.

E. CHILD'S BENEFITS--CHILD ENTITLED ON MORE THAN ONE E/R

1. Requirements

The 1972 amendments provide that a child who is entitled on more than one E/R can be paid benefits based on the E/R which will result in the highest benefit (even if such E/R has a PIA lower than the PIA of another E/R). However, the child can be paid on an E/R other than the E/R with the highest PIA only if such payment would not reduce the benefit amount of any person who is entitled on any of the E/R's involved.

2. Effective Date

This provision is effective with respect to monthly benefits payable for months after December 1972.

Purpose

Under prior law the benefits for a child entitled on more than one E/R were computed on the record with the highest PIA. This did not always result in paying the child the highest potential benefit amount because benefits for surviving children are 75 percent of the PIA, while benefits for children of retired or disabled workers are 50 percent of the PIA. The new provision is more equitable to children who may be entitled to benefits on more than one E/R.

F. 1972 RAILROAD RECOMPUTATION

1. General

The 1972 amendments provide that when social security has jurisdiction of a death claim, RR compensation will be combined with social security earnings and used in recomputing the PIA for determining the amount of the LSDP and any monthly survivor's benefits.

The 1972 railroad recomputation applies if:

a. the WE died after 1967; and
b. the WE was entitled to a RIB or DIB; and
c. SSA has jurisdiction of any survivor's claim.

Any computation method (including the 1967 simplified old start method) which is not specifically excluded by other requirements may be used for the 1972 RR recomputation.

2. Effective Date

The 1972 RR recomputation is effective with respect to LSDP and monthly survivor's benefit cases being processed on or after the date of enactment of the amendments. The recomputed PIA can be effective prior to the date of enactment.

Purpose

This provision corrects an unintended deliberalization resulting from the 1967 provisions for the simplified old-start computation method.

G. DEEMED WAGES FOR CERTAIN INTERNED INDIVIDUALS

1. General

The 1972 amendments provide deemed wage credits for individuals who were interned during World War II at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry.

Deemed wages will apply to such individuals for that part of the period December 7, 1941, through December 31, 1946, during which they were interned at such a facility and had attained age 18.

Except for "period of disability" insured status purposes, this provision does not apply if a benefit is paid by another agency or instrumentality of the United States based on internment during the period December 7, 1941, through December 31, 1946. Nor does the provision apply if a larger LSDP or larger monthly benefits result without its application.

2. Amount of Deemed Wages

a. If the individual was not employed prior to internment, his deemed wages for each full week of internment will be 40 times the minimum hourly rate in effect at such time; or

b. If the individual was employed prior to internment, his deemed wages for each full week of internment will be a multiple of 40 times the higher of: (i) the highest hourly rate he received prior to internment or (ii) the minimum hourly rate in effect at such time.

3. Effective Date

The provision is effective with respect to monthly benefits for months after December 1972 and with respect to LSDP's for deaths which occur after December 1972.

Purpose

These credits are intended to provide social security credit for U.S. citizens of Japanese ancestry using the presumption that they were unable to work and earn social security credits because of their internment during World War II.

H. CHILDHOOD DISABILITY SAVING CLAUSE

The benefit amount of any beneficiary entitled for 12/72 on the basis of an application filed in or before that month will not decrease for months after 12/72 due to the entitlement of a disabled child for 1/73 solely under the amendment provision (i.e., the disability began after age 17 and before age 22). The benefit amounts for months after 12/72 will be determined as if the disabled child had never been entitled.

I. ELIMINATION OF SUPPORT REQUIREMENT SAVING CLAUSE

The benefit amount of any beneficiary entitled for 12/72 on the basis of an application filed in or before that month will not be lowered for any month after 12/72 due to a surviving divorced mother becoming entitled. The benefit amount of such a protected beneficiary will be determined as if the surviving divorced mother were not entitled.

5100. ANNUAL EARNINGS TEST

A. Increased Earnings for Retirement Test Purposes

1. Initial Increase in Exempt Amounts

The 1972 Amendments provide for a new monthly exempt amount of $175 and a new yearly exempt amount of $175 times the number of months in the taxable year. Excess earnings for the retirement test purposes will be 50 percent of the earnings which exceed the yearly exempt amount. These changes are effective for taxable years ending after 1972.

a. The amount a beneficiary may earn in a 12-month taxable year and still receive all benefits for the year is increased from $1,680 to $2,100 (i.e., $175 times 12);

b. When earnings for a 12-month taxable year exceed the exempt amount, $1 in benefits is withheld for every $2 in earnings over $2,100;

c. The amount of wages a beneficiary may earn in a month without losing his benefit for that month has been raised from $140 to $175.

2. Subsequent Increase in Exempt Amounts

Whenever there is a benefit increase following a cost-of-living computation quarter, a corresponding increase in the monthly and yearly exempt amounts shall also be determined.

The Secretary must publish (whenever there has been a benefit increase) by November 1 of the year in which the computation quarter occurs, the exempt amount (whether or not there is a change) which would be effective with the taxable year which ends with the close of or after the taxable year in which the benefit increase is effective.

a. No change can be effective, if during the year the new exempt amount is published, a law is enacted increasing the exempt amount;

b. The monthly exempt amount for any year cannot go below the amount of the preceding year. It will either increase or stay the same.

Purpose

The increase to $2,100 in the annual exempt amount reflects the increase in general earnings levels since 1967, when the $1,680 exempt amount was established. Automatically increasing the exempt amount in the future will avoid extended lags between increases in earnings levels and changes in the test. Also, because there will no longer be a $1 reduction in benefits for each $1 in earnings above $2,880 as occurred under prior law, beneficiaries will be assured that the more they work and earn the more spendable income (that is, social security benefits plus earnings after taxes) they will have.

B. Earnings Excluded for Retirement Test Purposes

1. Exclusion of Earnings in or After Month of Attaining Age 72

The amendments provide that earnings in and after the month a person attains age 72 will not be used to determine earnings for retirement test purposes.

If the person is an employee, the wages earned in and after the month of attaining age 72 are excluded; if he is self-employed, his income will be prorated over the year in a manner to be prescribed by regulations.

Only earnings in those months in the year before the month of attainment of age 72 will be considered in determining the excess earnings to be charged.

The exclusion of earnings after age 72 is effective beginning with taxable years ending after December 1972.

Purpose

This change on earnings in the year a beneficiary reaches age 72 should eliminate substantial misunderstandings by beneficiaries who believed earnings in months after attainment of age 72 did not count for retirement test purposes under prior law.

2. Exclusion of Nonwork Payments to Men

The age after which nonwork payments to men are excluded under section 209(i) will be reduced to age 62 with respect to such payments after 1974. See section 1100 of this Summary for explanation of this provision.

5500. OVERPAYMENTS

A. Adjustment Against Beneficiary--Provider Without Fault in Medicare Overpayment

The 1972 amendments provide for adjustment of an overpayment under Medicare against the overpaid beneficiary (or against subsequent payments) in cases in which the provider of services or other person was without fault with respect to the overpayment.

Previously the beneficiary's liability for adjustment, etc., was limited to situations in which the overpayment could not be recovered from the provider or other person.

This amendment is effective with respect to notices sent after enactment.

B. Medicare Overpayments Discovered After Three Years

The 1972 amendments contain provisions applicable to cases in which the Secretary's determination of an overpayment under Medicare is made after the third year following the year in which notice of payment was sent to the beneficiary (e.g., notice sent in 1969, determination of overpayment in 1972). In such cases:

1. The provider of services or other person is deemed (in the absence of evidence to the contrary) to be without fault with respect to the overpayment; and

2. Adjustment or recovery of the overpayment from the beneficiary is deemed to be against equity and good conscience if the overpayment was made for expenses incurred for items or services for which payment could not be made under paragraph (1) (i.e., items or services not reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member) or paragraph (9) (i.e., for custodial care) of Section 1462 of the Act.

This new provision is applicable to notices sent after 1968.

C. Adjustment Against Subsequent Benefits

The 1972 amendments bar recovery or adjustment of a medicare overpayment against subsequent benefits if the individual entitled to such subsequent benefits is without fault in causing the overpayment and if recovery or adjustment would defeat the purpose of title II or title XVIII. If the overpayment is discovered after three years, section B, above, applies.

Previously, there was no provision for waiver of adjustment of a medicare overpayment against subsequent benefits if the overpaid beneficiary was at fault in causing the overpayment. Now such individual's fault will not preclude relief to the subsequent beneficiary.

This amendment applies to waivers considered after enactment.

D. Defeat Purpose of Title XVIII

The 1972 amendments bar recovery or adjustment of a medicare overpayment against an individual who is without fault if such recovery or adjustment would defeat the purpose of title XVIII.

This amendment is effective with respect to any case in which notice was sent to the individual after 1968.

Purpose

As noted above, prior law was inconsistent about waiver of recovery of Medicare overpayments--recovery from a beneficiary could be waived but not recovery from a provider of services or other overpaid person. The amendments eliminate this inconsistency. The amendments relating to waiver of adjustment or recovery of an overpayment found after 3 years have expired recognize the hardship that would result if recovery were made long after the payment was made. At the same time, setting a time limit within which claims for underpayment must be filed seems consistent with good accounting practices.

6000. DISABILITY PROVISIONS

A. INSURED STATUS FOR STATUTORY BLINDNESS

1. Disability Insured Status

An individual disabled by reason of statutory blindness may qualify for a disability freeze and/or DIB if he has fully insured status only. The 20/40 requirement and age 31 test have been eliminated for these individuals.

2. Effective Date

This new provision is effective for benefits payable for months beginning January 1973 based on applications filed in or after the month of enactment; or filed before the month of enactment if a final SSA determination has not been rendered (or a decision in a civil suit has not become final) before the month of enactment.

Purpose

Removing the substantial recent work test (generally 20 quarters of coverage in the period of 40 calendar quarters in the period preceding disablement), would permit blind people to be insured for disability protection on a basis comparable to that for retirement benefit protection. This is a reasonable basis for qualifying for disability protection on the part of a blind individual, who faces special employment problems.

B. INSURED STATUS REQUIREMENT FOR A DISABILITY FREEZE AND/OR DIB

1. Fully Insured Status

The fully insured status requirement for men has been liberalized. For a male WE born 1/2/13 or later, fully insured status is determined using elapsed years up to the years he attains age 62 or, if earlier, the year in which he became disabled. For a male WE born 1/1/13 or earlier, fully insured status is determined using elapsed years up to 1975 or, if earlier, the year in which the disability began.

2. Effective Date

This provision is effective for benefits payable for months beginning January 1973.

C. AGE 62 COMPUTATION POINT FOR MEN

1. Computation of DIB PIA

The DIB PIA for any male WE born 1/2/13 or later is computed as if he had attained age 62 in the first month of his waiting period or, the first month of entitlement to a DIB where there is no waiting period. The DIB PIA of a male WE born 1/1/13 or earlier is computed using elapsed years up to 1975 or, if earlier, the year in which the waiting period begins.

2. Effective Date

This provision is effective for benefits payable for months beginning January 1973.

Purpose (B. and C.)

Changing the ending point from 65 to 62 in determining insured status/ benefit amounts for men eliminates differences in the way these provisions apply to men and women--differences which, upon review, seem unwarranted.

D. WAITING PERIOD REQUIREMENT

1. Five-Month Waiting Period for Disability Freeze and/or DIB

An individual may qualify for a disability freeze if he has been disabled for five (rather than six) full calendar months. In addition, the waiting period requirement for entitlement to DIB or disabled widow(er) benefits is five full calendar months.

2. Effective Date

This provision is effective for benefits payable for months beginning January 1973 based on applications filed in or after the month of enactment; or filed before the month of enactment if a final SSA determination has not been rendered (or a decision in a civil suit has not become final) before the month of enactment.

Purpose

The protection against loss of income due to disability that many workers have under State disability benefit programs and under employer plans (such as group policies, sick-leave plans, or union-management plans) usually expires before a worker has been disabled for 6 months. By reducing the disability waiting period by 1 month, to 5 months, the financial hardship faced by the disabled worker and his family will be lessened to some extent. The first benefit will be payable for the sixth month of disability, rather than for the seventh month of disability, as under present law.

E. APPLICATION FIED AFTER DEATH OF WE

1. Requirement for Effective DIB Application after Death

In the case of a deceased individual the application requirement for a disability freeze and/or DIB may be satisfied by an application filed within three months after the month of the WE's death.

2. Effective Date

Entitlement may be established under this amendment based on the earnings record of an individual who dies in 1970 or later. For those individuals who die in 1970 or later but prior to the date of enactment, an application filed within three months after the month of enactment will be deemed filed in the month of death.

Purpose

In a relatively few cases a disabled worker who would have been eligible for benefits dies before an application is filed and his disability benefits are lost. As a result, the living expenses of the disabled worker during the period of his disablement may remain unpaid and become obligations of his survivors. This provision will help to alleviate some of the financial hardship on those survivors.

F. PROVISIONS FOR CHILDHOOD DISABILITY BENEFITS

1. Requirements for Entitlement

Childhood disability benefits are now payable to sons and daughters of any age who have been disabled continuously since before age 22. In addition, a child whose benefits are terminated at or after age 18 may be reentitled to a CDB if he later becomes disabled before age 22 or within seven years (84 months) following the month in which his most recent entitlement ended because his disability ceased.

2. Effective Date

This provision shall apply with respect to benefits payable for months beginning January 1973 except that in a case of an individual who was not entitled to a monthly benefit for December 1972, benefits will be payable only on the basis of an application filed after September 30, 1972.

Purpose

In many cases, the period of a child's dependency on the wage earner is extended beyond age 18 because the child spends additional years in school and does not have regular earnings before his twenties. Providing childhood disability benefits for a child who becomes totally disabled before age 22 recognizes this longer period of dependency.

Permitting reentitlement to childhood disability benefits within 7 years affords a former childhood disability beneficiary an opportunity to work long enough to gain disability protection as a worker. This change is consistent with present-law provisions which permit disabled widows and disabled dependent widowers to become reentitled to benefits if they again become disabled within 7 years after recovering from an earlier disability.

G. WORKMEN'S COMPENSATION OFFSET

1. Average Current Earnings

The 1972 amendments introduce a third method of determining an individual's "average current earnings" for purposes of limiting combined social security and workmen's compensation benefits. The amendment provides that the average current earnings may be the average monthly wage determined on the basis of the one calendar year (selected from the period consisting of the calendar year of onset and the five preceding years) in which the worker's earnings were highest.

An individual's average current earnings, therefore, will be the highest of the following:

a. The average monthly wage upon which the disability insurance benefit is based; or

b. The "high-5" average monthly wage; or

c. The "high-1" average monthly wage.

Under both methods b. and c., total earnings for maximum years used in computation will be estimated on the basis of earnings information in the records of the Administration.

2. Effective Date

This provision is effective for monthly benefits payable for months after December 1972.

Purpose

In some cases, the two alternative methods of computing a worker's average current earnings--the basis for the 80-percent ceiling for combined benefits--did not realistically reflect the worker's earnings level before disablement. The new additional alternative--while consistent with the principle that the combined benefits should not exceed 80 percent of the worker's earnings before he became disabled--does take into account the fact that earnings just prior to disablement may have been the highest.

H. PAYMENT IN CERTAIN CASES OF DISABILITY BENEFITS WITH RESPECT TO PERIODS OF DISABILITY WHICH ENDED PRIOR TO 1964

1. Lump-Sum Payment

The 1972 amendments provide for a lump-sum payment of disability benefits to certain individuals for whom a period of disability was previously established solely on the basis of provisions of the 1967 amendments extending the prescribed filing period due to WE's incapacity. Under the amendment provision, the following requirements must be met with respect to any individual potentially entitled to such payment:

a. The individual's period of disability must have begun after 1959 and ended prior to 1964; and

b. With respect to such period of disability:

(1) The individual or someone in his behalf must have filed an application not more than 36 months after the end of the period of disability (to establish entitlement to the period of disability); but

(2) The application was denied because it was not timely filed and failure to file during the prescribed period was due to a physical or mental condition which prevented him from filing timely; and

(3) The period of disability was subsequently established for such individual on the basis of an application filed before 2/1/69.

2. Benefit Payable

Any individual who meets all of the above requirements may be entitled to receive in a lump sum an amount equal to the total amount of disability insurance benefits which would have been payable for the established period of disability had an application for DIB been timely filed.

3. Effective Date

This lump sum will be payable after the date of enactment of the 1972 amendments, on the basis of an application filed not later than six months after the enactment date.

Purpose

Under the 1967 amendments, certain disabled people were allowed to establish a period of disability even though the period provided in the law for filing effective applications had expired. The 1967 provision was designed to protect a small number of people who, when the disability program was new, did not have the opportunity to file an application. This provision enables benefits to be paid for those periods of disability, which began after 1959 and ended prior to 1964.

Penalty for Furnishing False Information to Obtain Social Security Account Number, and for Deceptive Practices Involving Social Security Account Numbers

The 1972 amendments provide, in addition to the present statute providing criminal penalties for fraud against the Administration, that the furnishing of false information in order to deceive the Secretary for the purpose of obtaining an account number under a false identity is also punishable as a crime under the same provision (section 208 of the act).

In addition, it applies the same criminal penalties for the use of a number which has been obtained on the basis of false information, by any person, whether it be the same individual who furnished such information or not, where the purpose of such use is to fraudulently secure payment of benefits or an increase in such payment, not only under the Social Security Act but under any program financed in whole or in part from Federal funds.

The amendments also provide that anyone who falsely represents that a number is his, or has been assigned to another person, for the purpose of effectuating an initial or increased payment of benefits (under any program financed in whole or in part by Federal funds) is guilty of a violation and subject to the same penalties.

Effective date: These provisions are effective upon enactment.

Purpose

Social security numbers obtained by an individual under false identities can be used to evade taxes, or obtain payments (from, for example, public assistance) to which he is not entitled. Issuance of social security numbers to schoolchildren, to aliens permitted to work, and to public assistance beneficiaries, based on positive identification, and penalties for providing false information or for misusing a social security number, will make it difficult for an individual to obtain a number with false identification or for improper uses.

10000. HEALTH INSURANCE PROGRAM

PROGRAM ADMINISTRATION

A. Professional Standards Review

Authorizes the establishment of independent professional standards review organizations (PSRO's) by means of which practicing physicians will assume responsibility for reviewing the appropriateness and quality of the services provided under Medicare and Medicaid.

PSRO areas throughout the country will be established (by 1/1/74) on geographic or medical service area terms. Each area will generally contain a minimum of 300 practicing physicians, in most cases many more. In smaller or more sparsely populated States the entire State will probably be a PSRO area.

The PSRO will be responsible, within its area, for assuring that services were (1) medically necessary and (2) provided in accordance with professional standards. PSRO's will not be involved with reasonable charge determinations.

Beneficiaries, providers, or practitioners may request reconsideration of a PSRO determination. If the amount in controversy is $100 or more the appellant may request review of the reconsidered determination by a State Professional Standards Review Council or by the Secretary. If the amount in question exceeds $1,000, the Secretary's final decision is subject to judicial review.

Effective Date

1/1/74.

Purpose

Congress feels that while careful review of medical determinations relating to Medicare and Medicaid is essential, such review should not be performed by Government unless the medical profession evidences an unwillingness to properly assume the task. A number of prototype review organizations have been operating across the country and have convinced Congress that peer (physicians by physicians) review can and should be implemented. Use of such peer groups should lead to improved utilization and quality controls.

B. Modification of the Role of the Health Insurance Benefits Advisory Council (HIBAC)

The role of HIBAC will be limited to providing advice for the consideration of the Secretary on matters of general policy in the Medicare and Medicaid programs. It will no longer advise in the formulation of regulations nor study and make recommendations

on utilization of health care services. The Medical Assistance Advisory Council, which had functions similar to Medicare in regard to the Medicaid program, will be terminated.

Effective Date

Enactment.

Purpose

Much of the formulation of regulations and program policies for Medicare is done and there is little need for advisory assistance in this area any longer. In addition, the new National Professional Standards Review Council will undertake the former HIBAC functions in evaluation of the utilization of health care.

C. Disclosure of Information Concerning the Performance of Carriers, Intermediaries, State Agencies, and Providers of Services Under Medicare and Medicaid

The Secretary shall make available for public inspection the following types of evaluations and reports:

1. Formal evaluations of carriers, intermediaries, and State agencies;

2. Comparative evaluations of the performance of contractors; and

3. Formal evaluations of the performance of providers of services (without identification of individual patients, or other individuals).

Such reports will not be made public until the contractor or provider has had opportunity (not more than 60 days) to review and offer comments on the report.

Effective Date

Effective with reports completed after the third calendar month following enactment.

Purpose

To meet the need for public awareness of the deficiencies of contractors and provider performance and the accompanying pressures for improvements in administration that the awareness brings.

D. RRB Responsibility

The RRB will be responsible for premium collection from all RRB annuitants, regardless of whether they are, or subsequently become,

SSA beneficiaries. In addition, the RRB is authorized to select the carrier to make program payment on RRB's behalf.

Effective Date

This provision is effective for all premiums due and payable after the fourth month after the month of enactment.

Purpose

This provision is intended to simplify administration of the program by eliminating dual enrollment (RRB and SSA) and the consequent expense of determining jurisdiction.

E. Required Information Relating to Excess Medicare Tax Payments by Railroad Employees

The requirement that railroads include the amount of hospital insurance tax withheld on W-2 forms is deleted.

Effective Date

Applies to remuneration paid after December 31, 1971

Purpose

The difficulties of administering the prior provision exceeded the benefits. However, employees will be notified that those with dual employment may be entitled to a refund of excess hospital insurance tax paid.

CERTIFICATION PROGRAM

F. Validation of Surveys Made by Joint Commission on the Accreditation of Hospitals

The Medicare provider conditions of participation and certification process are linked to JCAH requirements and accreditation. To validate JCAH standards and surveys, the Secretary is authorized to enter into an agreement with any State to have the State certification agency survey hospitals accredited by the JCAH on a selective sample basis, or a specific hospital where the Secretary directs on the basis of substantial allegations and evidence of a condition adverse to health and safety. If a surveyed institution is found to have significant deficiencies relative to Medicare health and safety standards, the institution may be terminated from participation in the program.

An institution certified on the basis of JCAH accreditation must agree to authorize JCAH to release to the Secretary a copy of the most current JCAH accreditation survey if it is included in a validation survey.

The Secretary may after consultation with JCAH, promulgate health and safety standards higher or more precise than JCAH standards.

Effective Date

Enactment.

Purpose

Provides a mechanism for reasonable continuing validation of the voluntary accreditation process without duplicating that process.

G. Disclosure of Survey Reports

The bill requires the Secretary to make available to the public information from surveys of providers relating to the presence or absence of deficiencies in areas such as staffing, fire safety, and sanitation. Following completion of a survey of a health care facility or organization, those portions of the survey findings relating to statutory requirements as well as major additional health and safety requirements will be matters of public record. Such information will be available for inspection within 90 days of completion of the survey upon request in social security district offices.

Effective Date

This provision is effective with surveys completed after the sixth month following the month of enactment.

Purpose

By having this information available, physicians and the public will be able to choose among the health facilities. They will also be able to bring pressure upon deficient institutions to correct their shortcomings.

H. Proficiency Testing for Health Personnel

The bill requires the Secretary (in conjunction with appropriate professional health organizations and State health and licensure agencies) to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present Medicare regulations. Such testing program would be applied through December 31, 1977, after which persons entering the health care fields in question would need to meet the regular formal education, professional membership, or other requirements.

Effective Date

Enactment.

Purpose

The intent is that experienced practical nurses, therapists, laboratory technicians, etc., shall have an opportunity to demonstrate that they can properly perform their duties even though they may lack certain formal education or training, or to determine the additional training required to bring them up to a qualifying level.

I. Institutional Planning Under Medicare

As an additional condition of participation under the Medicare program providers of services are required to have a written plan reflecting an operating budget and a capital expenditures plan. Hospitals accredited by the Joint Commission on Accreditation of Hospitals are also subject to the condition.

Effective Date

Effective for provider fiscal years starting after the fifth month following enactment.

Purpose

This provision, by requiring detailed budgets and operating plans, is intended to effect the management efficiencies that are inherent in such procedures.

10100. HOSPITAL INSURANCE BENEFITS - ENTITLEMENT

A. HI for Disabled

1. Individuals who have been receiving DIB for 24 consecutive months under either title II or under the RR Act will be entitled to HI benefits and could enroll in SMI.

2. Recipients of mother's benefits for 24 consecutive months who meet the requirements for DIB except for the filing of a disability claim, could, under a special provision, file a disability claim until July 1, 1974, establish up to 24 months retroactivity, and become entitled to HI.

Effective Coverage Date

HI coverage begins no earlier than July 1973 for those qualifying.

Termination of HI

HI coverage extends through the month following the month notice of termination of DI is mailed.

Purpose

Individuals receiving DIB have a greater need for health care services, and generally, a lesser ability to pay for them. By establishing a 24-month "waiting period," program costs are lessened by assistance in paying for needed health care will be provided to those beneficiaries who most need it.

B. Health Insurance Coverage of Persons Needing Kidney Transplantation or Dialysis

An individual who is fully or currently insured, or a spouse or dependent child of a fully or currently insured individual, who requires hemodialysis or renal transplantation for a chronic renal disease is deemed disabled for HIB and SMIB coverage purposes. All Part A and Part B benefits are payable.

Coverage Beginning Date

The individual's eligibility for coverage begins with the 3rd month after the month in which a course of renal hemodialysis begins.

Coverage Termination Date

The individual's deemed coverage ends 12 months after the month the individual has a transplant or dialysis treatment stops.

Effective Date

This provision is effective July 1, 1973.

Purpose

Many people who otherwise would be considered disabled under social security and thereby eligible under Medicare are able to work because they are receiving dialysis. Coverage under Medicare in light of the extremely high cost of treatment was deemed appropriate and necessary.

C. Hospital Insurance on a Paid Enrollment Basis

An individual, otherwise not eligible for HIB may enroll for a monthly premium for Part A coverage of $33 for the first year.

States and public organizations, through agreements with the Secretary, are permitted to purchase such protection on a group basis for their aged retired (or active) employees.

Requirements for Enrollment

1. Age 65,
2. Must also enroll in SMI,
3. Resident of the U.S.: and
   (a) citizen; or
   (b) an alien lawfully admitted for permanent resident who has resided in the U.S. continuously for at least 5 years.

Enrollment

Enrollment periods and procedures will be established by regulations. Individuals who enroll late will pay a higher premium. The same restrictions on enrollment and reenrollment as for SMI apply.

Effective Date

Coverage cannot begin earlier than July 1, 1973.

Termination

An enrollee's entitlement will end:

1. Voluntary withdrawal - at the end of the month following the month in which the notice was filed.

2. With the month before the month in which he becomes entitled to

regular HIB - the individual is deemed to have filed in the first month required so as to provide continuous HIB entitlement.

3. Termination of SMI - an individual's entitlement to HIB under this provision ends simultaneously with the termination of his SMI participation.

Purpose

This provision will ease the financial burden for individuals who will not otherwise be covered by Medicare when the special transitional provision which provides HIB protection for individuals not entitled to monthly benefits phases out in 1974.

10200. SUPPLEMENTARY MEDICAL INSURANCE - ENTITLEMENT

A. Automatic Enrollment

Beneficiaries receiving monthly benefits (SSA or RRB) prior to age 65 will be deemed to have enrolled in SMI the month before the month for which they became entitled to HI, so that HI and SMI coverage will start the same month. Thus, monthly beneficiaries other than disability will be deemed to enroll the month before attainment of age 65. Disability beneficiaries will be deemed to enroll in the 24th consecutive month of receiving benefits.

Individuals not yet entitled to monthly benefits will be deemed to have enrolled for SMI in the month in which they file to establish entitlement to HI and the beginning of SMI coverage determined accordingly.

An individual can decline SMI enrollment by filing notice prior to the beginning of his coverage period and he will be considered not to have enrolled. A notice filed after the coverage period begins will be treated as a withdrawal under existing disenrollment rules.

This provision does not apply to residents of Puerto Rico or foreign countries.

Effective Date

This provision is effective July 1, 1973.

Purpose

The purpose of this provision is to prevent the individual's loss or delay of entitlement to SMI because of his failure to take timely, positive action.

Residents of Puerto Rico and foreign countries are excluded because it would usually be to their disadvantage to enroll. SMI does not cover services or items outside the United States for foreign residents who would be protected only while traveling in the United States. Residents of Puerto Rico generally are eligible for comprehensive health care which eliminates the need for SMI.

B. Waiver of Enrollment Period Requirements - Administrative Error

The Secretary may take action necessary to correct an unintentional, inadvertent, or erroneous enrollment or nonenrollment which was based upon the error, misrepresentation, or inaction of a government officer, employee, or agent. The action may include designating special individual enrollment periods and premium adjustments.

Effective Date

This provision will apply to all Part B cases which have arisen since the program began on July 1, 1966. The Administration will not be required to search for cases which arose prior to enactment of the provision. It will also apply to the new Part A enrollment for the uninsured (10100).

Purpose

This provision is intended to provide relief for beneficiaries whose rights were prejudiced by administrative error.

C. Elimination of 3-Year Limit on Enrollment or Reenrollment

The requirement that an eligible individual must enroll in a general enrollment period which begins within 3 years after the end of his initial enrollment period, or reenroll during a general enrollment period which begins within 3 years after the termination of his entitlement to SMI, is eliminated.

There is no change in the provisions which permit only one re-enrollment after termination, and provide for 10 percent increase in the premium for each 12 months that the individual could have been, but was not, entitled.

Effective Date

This provision is effective with the first general enrollment period after enactment. It applies to those who were ineligible to enroll because of the 3-year limit under prior law. Months in which the law precluded enrollment because of the 3-year limit will not be counted in determining the premium.

Purpose

The vast majority of individuals enroll when first eligible. Thus, the 3-year limitation--intended to protect the program against the possibility that many individuals would delay enrolling until they actually became ill--serves no significant purpose. Retention of the premium increase for late enrollments is considered an adequate deterrent to delayed enrollments and will meet the higher costs associated with older enrollees.

10400. HEALTH INSURANCE PREMIUM COLLECTIONS

A. Premium Determination

As heretofore each December, the Secretary will determine and announce the amount of the SMI premium for the 12 months beginning the following July. A revised method of determining the premium will be used.

The amount of the premium will be the lesser of:

1. One-half of the estimated monthly cost per enrollee of the program, including benefit payments and administrative costs, plus a small reserve in the year beginning the following July (the amount used to determine the premium under prior law); or

2. The amount of the current premium increased by a percentage equal to that by which monthly benefits have, or are scheduled, to increase during the 12-month period to which the current premium rate applies.

General revenues will be used to meet program costs not met as a result of this provision.

Effective Date

The revised method of determining the premium will apply to the premium for the year beginning July 1973.

Purpose

The effect of the revised method of premium determination is to limit premium increases to the same percentage that cash benefits are increased. The financial burden to beneficiaries will be mitigated by relating premium increases to the beneficiary's ability to meet the cost.

B. Extension of Grace Period Where There is Good Cause for Failure to Pay Premiums Timely

The 90-day grace period for paying overdue SMI premiums and continuing SMI coverage may be extended for good cause for up to an additional 90 days.

Effective Date

This provision applies on enactment and to unpaid premiums due within the 90-day period preceding the date of enactment.

Purpose

Some enrollees have been terminated for nonpayment of premium when they mistakenly thought payment had been made. In other cases, the beneficiary was physically or mentally incapacitated and had no one acting on his behalf. This provision corrects this inequity.

10500. CLAIMS PROCESS - PROVIDER SERVICES

A. Covered Foreign Services

Inpatient hospital services furnished by, or under arrangements with, a foreign hospital that has been accredited by the JCAH or a hospital approval program with essentially comparable standards are covered for residents of the U.S. if the foreign hospital is closer to, or substantially more accessible from, the beneficiary's residence than the nearest hospital in the U.S. that is suitable and available for his treatment. Coverage is also extended in these cases to physicians' and ambulance services furnished in conjunction with covered foreign hospital care. For these U.S. residents benefits are payable without regard to whether an emergency existed or where the illness or accident occurred.

The present provisions covering emergency inpatient hospital services outside the U.S. when the emergency arises in the U.S. are retained. They are extended to cover beneficiaries who incur an emergency in Canada while enroute between Alaska and another State. Such beneficiaries must be traveling by the most direct route without unreasonable delay.

Reimbursement for Foreign Hospital Services

If the hospital elects to bill the Medicare program, it will be reimbursed on the basis of reasonable cost (if it furnishes actual cost data). Otherwise, reimbursement will be to the beneficiary. Subject to the deductibles and coinsurance, the beneficiary would receive 60 percent of reasonable charges for "routine services" and 80 percent of reasonable charges for "ancillary services." If the hospital did not charge separately for routine and ancillary services, the beneficiary would receive two-thirds of the hospital's total charges. These reimbursement methods are essentially the same as for nonparticipating hospitals in the U.S.

Reimbursement for Physicians' and Ambulance Services

Foreign physicians' and ambulance services furnished in conjunction with foreign inpatient services are covered only for the period during which the inpatient hospital services were furnished. They may be reimbursed only through the itemized bill method of reimbursement. The assignment method may not be used. The Secretary is authorized to establish reasonable limitations on the amount of the foreign physicians' charge that would be accepted as reimbursable under the Medicare program.

Effective Date

These provisions apply to admissions after December 31, 1972.

Purpose

These changes recognize that a foreign hospital is the logical provider of inpatient services for certain U.S. residents and permit coverage of services for these beneficiaries. The extension of emergency services coverage recognizes that Canada may be the logical route between Alaska and other States.

10600. SMI CLAIMS PROCESS--PHYSICIANS' AND SUPPLIERS' SERVICES

A. Extension of Time for Filing SMI Claims When Delay is Due to Administrative Error

Notwithstanding the normal time limit in which an SMI claim must be filed for program payment to be made, the beneficiary can file and receive payment for an SMI claim not filed timely because of an error or misrepresentation by an officer, employee, intermediary, carrier or agent of DHEW. Request for payment must be submitted promptly after the error is corrected.

Effective Date

This provision applies to all bills or requests for payment made after March 1968.

Purpose

Some beneficiaries have failed to file SMI claims because of a mistake or other action of the Government or its agents. This provision would provide them with an opportunity to file these claims.

B. Direct Laboratory Billing of Patients

The Secretary is authorized to negotiate a payment rate with laboratories for Medicare diagnostic laboratory tests where the laboratory accepts assignment from the beneficiary. This rate would be paid in full by Medicare and be considered the full charge for the test. The amount of the rate cannot exceed the total amount that would have been payable without such a rate.

Effective Date

Enactment.

Purpose

Should result in cost reduction to both beneficiaries and the program by eliminating the cost to laboratories of billing beneficiaries for very small coinsurance amounts.

C. Prohibition Against Reassignment of Benefit Claims

Program payment may be made only to the patient or to the physician or supplier who provided the service and accepted assignment except that (1) payment may be made to the employer of the physician (or supplier) if the latter is required as a condition of employment to turn his fees over to the employer, or (2) payment may be made to the facility where the services were provided if the facility

has a contractual arrangement giving it the sole right to bill for the services (e.g., the arrangement of a hospital-based physician with his hospital). Also, direct payment could be made to an organization administering a health care delivery system, e.g., a prepaid group practice plan.

This provision would not preclude the physician or other person who provided the services and accepted assignment from having the payment mailed to any organization he wishes, but the payment would have to be in his name.

Effective Date

This provision applies to all bills submitted after enactment.

Purpose

In the past, some assigned claims have been reassigned to other organizations which, in turn, have billed the program. This has resulted in incorrect and inflated claims which have made reasonable charge and overpayment determinations difficult.

A. Waiver of Beneficiary Liability in Certain Disallowed Claims

1. A beneficiary who was without fault (i.e., did not know and could not be expected to know that the services were not covered) and whose claim under Part A or Part B has been disallowed because the services were not reasonable or necessary for the diagnosis or treatment of an injury or illness, or because the care was a noncovered level of care, shall not be liable for payment.

2. If the provider in such a case also exercises due care (i.e., did not know and could not be expected to know noncovered services were involved) the Medicare program will make payment as if the services were covered. When payment is made, the provider and patient would be put on notice so that they could not again claim lack of knowledge in subsequent claims involving similar situations.

3. If the provider did not exercise due care and the beneficiary was without fault, the provider would be liable but could appeal both the determination as to coverage and "due care." If the provider who did not exercise due care collected from the beneficiary, the program would upon application reimburse the beneficiary (subject to deductible and coinsurance amounts). These monies would be treated as overpayments to the provider and would be subject to the usual recovery procedures.

The provision applies also to Part B claims involving physicians and suppliers who accept assignment.

Effective Date

This provision is effective to claims for services provided after the month of enactment.

Purpose

This would eliminate situations in which a beneficiary is liable for payment even though he acted in good faith and did not know the services he received were not covered, and even though the hospital, physician, or other provider of services was at fault.

B. Waiver of Recovery of Overpayment from Survivor Who is Without Fault

A survivor of a deceased overpaid Medicare beneficiary shall not be liable for the overpayment when:

1. He was without fault, and

2. Recovery would defeat the purposes of title II or would be against equity and good conscience.

Effective Date

This provision will apply to all waiver actions considered after the date of enactment.

Purpose

This provision is intended to provide survivors with the same waiver rights that the beneficiary had before death.

C. Refund of Overpaid Premiums to Survivors

The bill provides for the refund of HI or SMI premiums paid by or on behalf of a deceased individual for months after the month of death. The refund will be made to the person who paid the premiums, the legal representative of the estate or other survivor in the same priority order as for unpaid SMI benefits.

Effective Date

This provision is effective upon enactment.

Purpose

The purpose of this provision is to provide the Secretary with legal authority to dispose of excess SMI and HIB premiums.

D. Limitations on Adjustment or Recovery of Incorrect Payments

1. In the absence of evidence to the contrary, when 3 years have expired after the year in which payment was made, there will be a presumption that the provider or supplier was without fault for any erroneous payment and no collection of such funds will be made from the provider or supplier.

   The Secretary is authorized to reduce the 3-year period to not less than one year if such a reduction would be consistent with program objectives.

2. Where an overpayment has been made because the services were not medically necessary or a non-covered level of care service was involved, recovery or adjustment of the overpayment from the beneficiary will be waived if 3 years have elapsed since the payment was made and if the beneficiary is without fault with respect to the overpayment.

   The Secretary is authorized to reduce the 3-year period to not less than one year if such reduction would be consistent with program objectives.

3. A provider under Part A, or a physician or other supplier who accepted assignment under Part B, cannot, after refunding an overpayment for medically unnecessary or noncovered level of care services, charge the beneficiary or enrollee who is without fault after 3 years (or not less than one year, if determined by the Secretary) have expired.

4. The Secretary is authorized to deny claims for reimbursement for services rendered by a provider of service under either Part A or Part B filed after a reasonable period (from 1 to 3 years as determined by the Secretary).

Effective Date

The limit on the right to recovery applies to notices of payment sent after 1968. The limitation on the filing of claims applies to requests made after 1970.

Purpose

The primary purpose of this provision is to limit recovery attempts to a reasonable period of time after an overpayment is made.

E. Withholding Medicaid Payments to Terminated Medicare Providers

The Secretary is authorized to withhold (after 60 days advance notice to a State) future Federal financial participation in State Medicaid payments to institutions which have withdrawn from Medicare without refunding Medicare overpayments or accounting for Medicare payments to them.

Effective Date

Enactment.

Purpose

Designed to recover funds that have been overpaid to terminated Medicare providers.

10750. MEDICARE PROGRAM INTEGRITY

A. Authority to Terminate Payments to Supplier of Services

The Secretary is given authority to terminate payment, with public notice, for services rendered by an institutional provider of services, a physician, or any other supplier of health and medical services determined by the Secretary to be engaging in overcharging, furnishing excessive, inferior or harmful services, or making a false statement to obtain payment. The termination will remain in effect until the Secretary gives notice to the public that the basis has been removed and there is reasonable assurance it will not recur.

Dissatisfied parties to such a determination are entitled to a hearing and, if still dissatisfied, to judicial review.

State program review teams composed of physicians, other health care professionals, and consumer representatives, will be established to review program utilization data and particular cases in which abuses may have been committed.

Effective Date

Date of enactment.

Purpose

The existence of this authority and its use in even a relatively few cases is expected to provide a substantial deterrent to program abuses.

B. Specification of Penalties for Fraud and False Reporting Under Medicare

Acts subject to penalty under the Medicare program are defined and penalties specified as follows.

1. In connection with furnishing items or services: The soliciting, offering, or accepting of kickbacks or bribes, or rebates. (Penalty: $10,000 fine or one year prison, or both.)

2. In connection with program payments:

   a. The making of false statements or representations of material facts in any application for, or determination of rights to, program payment.

   b. The concealing or the failing to disclose knowledge of any event affecting a person's right to any benefit payment with the intent to defraud.

c. Knowingly and willfully converting benefits or payments received on behalf of another to improper use. (Penalty: $10,000 fine or one year prison, or both.)

3. In connection with certification of providers: Knowingly and willfully making, or inducing or trying to induce the making, of a false statement with respect to the conditions and operation of a health facility to permit the facility to participate as a provider under title XVIII. (Penalty: $2,000 fine or 6 months prison, or both.)

Effective Date

The provision applies only to acts committed after enactment.

Purpose

Under existing law no specific penalties were provided for certain practices which are regarded by professional organizations as unethical, are unlawful in some jurisdictions, and which add to program costs.

C. Authority of Secretary to Administer Oaths in Medicare Proceedings

The Secretary is authorized to administer oaths and affirmations in the course of any hearing, investigation, or other proceeding under Medicare.

Effective Date

Enactment.

Purpose

Provides statutory authority for administration of oaths when necessary in Medicare proceedings.

10800. HEALTH INSURANCE APPEALS PROCESS

A. Requirement for SMI Hearing - $100 or More in Controversy

An enrollee, dissatisfied with the review determination of his SMI claim, may file for a fair hearing, but only if $100 or more is at issue.

Effective Date

This provision is effective for all hearing requests filed after enactment.

Purpose

Frequently, a hearing has cost $100 or more, yet the amount at issue was as little as $5 or $10. Almost 45 percent of hearings have involved less than $100. By setting the $100 requirement, administrative costs will be reduced. Enrollee's rights in small claims cases are adequately protected by the right to review.

B. Reimbursement Appeals by Providers

The Secretary will appoint a Provider Reimbursement Review Board (composed of 5 members knowledgeable in the field of cost reimbursement) to review appeals by providers when the intermediary makes a final cost determination with which the provider is dissatisfied, at least $10,000 is involved and the provider files the appeal within 180 days of the determination. Groups of providers can file an appeal on common issues when the aggregate amount involved is at least $50,000.

A provider which believes that its intermediary has not made a timely cost determination, can also file an appeal if $10,000 is involved.

The Secretary may on his own motion, within 60 days, reverse or modify a Board decision favorable to the provider. In that event, the provider has a right to judicial review.

Effective Date

This provision is effective for accounting periods ending on or after June 30, 1973.

Purpose

To provide a specific procedure in the law to enable providers to appeal an intermediary's final reasonable cost determination to assist in reaching reasonable and satisfactory settlements of disputes.

C. Medicare Appeals Clarification

There is no authorization for an appeal to the Secretary or for judicial review when Part B (SMI) benefits are involved. An individual can appeal to the Secretary in Part A (HI) benefit amount determinations only when the amount at issue is $100 or more. Judicial review is available if the amount at issue is $1,000 or more.

Purpose

This provision is intended to clarify, and thus eliminate the possibility of misinterpretation, of the requirements for appeal to the Secretary or the courts.

11100. COVERED SERVICES--HOSPITAL INSURANCE

A. Modification of the 14-Day Transfer Requirement for Extended Care Benefits

The requirement that a beneficiary is entitled to extended care benefits only if he is transferred to a skilled nursing facility within 14 days of discharge from a hospital can be waived if:

1. Nonavailability of appropriate bed space in his geographic area prevented admission during the 14-day period. In this case, transfer must be within 28 days after hospital discharge. Or,

2. The patient's condition did not permit provision of skilled nursing or rehabilitation services within the 14-day period. (For example, a patient with a fractured hip who requires little skilled care for some time after hospital discharge because the fracture has not mended to the point where physical therapy and restorative nursing can be utilized.) In this case, transfer must be within a time medically appropriate to begin active treatment.

Effective Date

Date of enactment.

Purpose

This corrects inequities caused by the inflexibility of the 14-day transfer requirement, where failure to begin extended care within 14 days was beyond the patient's control although the services are a continuation of treatment begun in the hospital.

B. Definition of Care in Skilled Nursing Facilities

A single common definition of care requirements for extended care services under Medicare and skilled nursing services under Medicaid is established as follows: Skilled nursing care provided directly by or requiring the supervision of skilled nursing personnel or other skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis. The Medicare requirement that the services must be a continuation of treatment for a condition treated in a hospital is retained.

For Medicare patients this covers two classes of patients who may not have been covered before:

1. The patient who needs a variety of unskilled services on a regular daily basis if the planning and overseeing of the aggregate of the unskilled services requires regular daily involvement of skilled personnel.

2. The patient who is in regular need of skilled rehabilitation services (other than nursing) which are essential to his recovery from an inhospital stay or to prevent his condition from worsening and which as a practical matter should be provided in an institution.

Effective Date

This provision applies to services furnished on or after January 1, 1973.

Purpose

The definition for extended care services was revised to assure that the benefits are payable on behalf of those types of patients who can best utilize the skilled types of services available in such institutions.

C. Advance Approval of Extended Care and Home Health Coverage

The Secretary is authorized to establish in regulations, by medical conditions and length of stay or number of visits, minimum periods during which beneficiaries would be presumed to be eligible and payment made for ECF or HHA benefits after hospitalization. The attending physician will certify prior to or at the time of admission (or prior to the first visit in the case of home health services) the condition is one designated in the regulations and will furnish a plan of treatment. Certifications and patient stays will be reviewed and if there is abuse of the advance approval procedure, the procedure will be suspended for the physician involved.

For conditions for which specific presumed coverage periods cannot be established, and for services beyond the presumed coverage period, the usual procedures for determining coverage will apply.

Effective Date

This provision is effective for ECF admissions and home health plans initiated January 1, 1973.

Purpose

This provision should improve utilization of ECF's and HHA's in lieu of extended hospitalization and should reduce the number of retroactive denials of ECF and HHA services.

D. Stopping Payment Where Hospital Admission Not Necessary Under Medicare

If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where

institutionalization is no longer necessary, payment would be cut off after 3 days.

Effective Date

Effective for services furnished after the second month following the month of enactment.

Purpose

This provision parallels the provision concerning utilization review committee findings on review of long-stay cases.

E. Limitation on Costs Recognized as Reasonable

The Secretary of Health, Education, and Welfare is given authority to set limits on provider costs to be recognized as reasonable under Medicare based on comparisons of the costs of covered services by various classes of providers in the same geographical area.

Providers of services will be allowed to charge beneficiaries for the unreimbursed costs of services in excess of, or more expensive than, those that are found necessary to the efficient delivery of needed health services (except in the case of an admission by a physician who has a financial interest in the facility). The Secretary will give public notice of the charges to Medicare patients being made by particular providers for excessive services and the provider will be required to identify such charges to the patient prior to admission.

Effective Date

Effective for provider accounting periods beginning after December 31, 1972.

Purpose

The intent is to limit program reimbursement to costs that would be incurred by a reasonably prudent and cost-conscious management and not to reimburse unusually expensive (luxury) service.

F. Coverage of Podiatric Residents and Interns

A teaching program approved by the Council on Podiatry Education is added to the "approved" teaching programs. Services to hospital inpatients by residents and interns in such approved teaching programs are covered under hospital insurance.

Effective Date

For accounting periods beginning after December 31, 1972.

Purpose

Makes "approved" teaching programs consistent with the fact that the 1967 amendments extended the definition of physician to include podiatrists.

11200. DEFINITIONS--HEALTH INSURANCE

SKILLED NURSING FACILITIES (FORMERLY ECF'S)

A. Designation of Extended Care Facilities and Skilled Nursing Homes as Skilled Nursing Facilities

Provides that wherever the term "extended care facility" appears in title XVIII or the term "skilled nursing home" appears in title XIX, the term "skilled nursing facility" shall be substituted.

Effective Date

Enactment.

Purpose

Provides identical nomenclature for the same type of facility in both the Medicare and Medicaid programs.

B. Uniform Standards for Skilled Nursing Facilities Under Medicare and Medicaid

A facility which meets the definition of "skilled nursing facility" can participate in both the Medicare and Medicaid programs provided it agrees to contract terms.

The definition of a "skilled nursing facility" is the existing definition in the law of "extended care facility" with 3 additional requirements.

1. The facility must supply complete information as to the identity of each person who has an ownership interest of at least 10 percentum; if it is organized as a corporation, the names of each officer and director; if organized as a partnership, the name of each partner; and agree to report any such changes.

2. The facility must cooperate in an effective program of independent medical evaluation and audit of its patients, including the patient's need for skilled nursing services.

3. The facility must meet the Life Safety Code of the National Fire Protection Association requirements applicable to nursing homes.

   The restriction against title XVIII payment to a facility which is primarily for the care and treatment of mental diseases and tuberculosis does not apply to title XIX.

Effective Date

This provision is effective July 1, 1973.

Purpose

Skilled nursing facilities which participate in Medicare or Medicaid generally must meet identical requirements. However, there are differences in the way the regulations are interpreted in the various States. This provision should eliminate any differences. It will enable one certification process for both programs and thus reduce program administrative costs.

C. Authorization for the Secretary to Determine Whether a Facility Is Qualified to Participate as a "Skilled Nursing Facility" In Both Medicare and Medicaid

Provides that the Secretary will certify those skilled nursing facilities that request participation in both the Medicare and Medicaid programs. (States will continue to certify those skilled nursing facilities that request participation in the Medicaid program only. The Secretary has always certified those requesting participation in the Medicare program.)

In addition, provider agreements without fixed expiration dates will no longer be used with skilled nursing facilities (formerly ECF's). In the future, the agreements will be limited to 12-months' duration.

Effective Date

Medicare agreements in effect prior to enactment will be deemed to expire no later than 12/31/73.

Purpose

The first provision does away with duplicative surveys for facilities that request participation in both Medicare and Medicaid and assures uniform national standards are applied to such institutions. The second provision does away with prior difficulties and delays in decertifying a facility with deficiencies.

D. Waiver of Requirement of Registered Professional Nurses in Skilled Nursing Facilities in Rural Areas

The Secretary is authorized to waive the requirement that a skilled nursing facility must employ a registered nurse full time (to the extent that "full time" is deemed to mean more than 40 hours a week) for certain rural skilled nursing facilities which are unable to assure the presence of a full-time registered nurse 7 days a week. A rural skilled nursing facility which has one full-time registered nurse and is making good-faith efforts to obtain another would be allowed a special waiver of the nursing requirement with respect to not more than two day shifts, such as over a weekend. This special waiver would be authorized if the facility has only patients whose physicians indicated that each such patient could be without a registered nurse's services for a 48-hour period. If the facility

has any patients for whom physicians have indicated a need for daily skilled nursing services, the facility would have to make arrangements for a registered nurse or a physician to spend such time as is necessary at the facility to provide the skilled services needed.

Effective Date

Enactment.

Purpose

This is a recognition of the shortage of registered nurses in certain rural areas.

E. Consultants for Skilled Nursing Facilities (formerly ECF's)

State certifying agencies may, subject to approval by the Secretary, provide such consultative services to a skilled nursing facility (e.g., as on maintenance of medical records or policy on provision of dietary services) as the facility may need to meet the conditions of participation.

Effective Date

Enactment.

Purpose

This amendment recognizes the shortage of such consultants in the private field and the fact that some State agencies are already providing such services for the Medicaid program.

F. Medical Social Services Requirement in Skilled Nursing Facilities

The Secretary cannot require as a condition for a skilled nursing home to participate in the program that it provide medical social services.

Effective Date

Enactment.

Purpose

A requirement for social services is considered not essential to the basic objectives of extended care.

G. Payments to Health Maintenance Organizations

A health maintenance organization (HMO) is an organization which provides comprehensive health services on a per capita prepayment basis.

An established HMO may qualify for incentive reimbursement under Medicare by entering into a contract with the Secretary. The contract would specify the amount, on a per capita basis, which the HMO would receive monthly and in advance. At the end of the fiscal year, the HMO would submit certified financial statements which would enable the Secretary to determine the average per capita cost had the services been provided Medicare beneficiaries through other health care arrangements. If the HMO's incurred costs were less than this amount, the difference (savings) would be shared by the HMO and the Trust Funds according to a prescribed formula.

An HMO which does not meet the requirements to be considered "established" may receive interim monthly capitation payments which, at the end of the fiscal year, would be adjusted to reflect the actual reasonable costs of providing Medicare services. A new HMO could, when it meets the requirements, qualify as an established HMO and contract for the incentive capitation basis.

A beneficiary enrolled with an established HMO which uses the risk-sharing method of reimbursement would receive covered services only through the HMO, except for emergency services, and urgently needed services received when he was temporarily outside the HMO's service area. A beneficiary enrolled in an HMO receiving cost reimbursement would not be required to use the HMO as his single source of health care. Payment would be made by Medicare in the usual manner for services he received outside the HMO.

Effective Date

This provision is effective with respect to services furnished on or after July 1, 1973.

Purpose

The purpose of this provision is to provide an incentive to furnish Medicare covered services at less cost, but with no decrease in quality or quantity.

H. Reimbursement Demonstration Projects and Experiments

The Secretary is authorized to develop and carry out experiments and demonstration projects to determine the relative advantages of alternative methods of making program payment on a prospective basis to providers. (Under prospective reimbursement, the rate of payment is set in advance and the provider presumably has an incentive to reduce actual costs below program payments.)

The purpose of this provision is to encourage providers by positive or negative financial incentives, to plan, innovate, and manage more effectively to achieve greater financial reward for the provider while lowering program costs.

In addition, the Secretary is authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy (including payment for services furnished by organizations providing comprehensive, mental, or ambulatory health care services, including ambulatory surgical centers); with performance incentives for intermediaries and carriers; with reimbursement implications of paying for services rendered by physicians' assistants; with the use of intermediate care and homemaker services by beneficiaries who either are ready for discharge from a hospital or are unable to maintain themselves at home without assistance; with programs designed to improve the rehabilitation or patients in long-term health care facilities; and to determine whether services of clinical psychologists might be made more generally available to persons eligible under Medicare.

Effective Date

The Secretary's report on the experiments and demonstration projects must be submitted to the Congress no later than July 1, 1974.

I. Provider Therapy Services Furnished Under Arrangements

Program payment to providers for the reasonable cost of covered physical, occupational, speech or other therapy services furnished under arrangements with others cannot exceed an amount equivalent to the salary and other costs which would have been payable if the services had been performed in an employment relationship, plus the expenses an individual not working as an employee might have, such as maintaining an office, travel expense, and similar costs.

Effective Date

This provision applies to accounting periods beginning on or after January 1, 1973.

Purpose

This provision is designed to control program expenditures and to help prevent program abuses.

J. Limits on Prevailing Charge Levels

Physicians' charges determined to be reasonable under the present criteria in the Medicare, Medicaid, and maternal and child health laws would be limited by providing: (a) that after December 31, 1970, medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the calendar year prior to the start of the fiscal year;

(b) that for fiscal year 1974 and thereafter, the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widely and consistently available in a locality.

The Health Insurance Benefits Advisory Council is to conduct a study of the methods of reimbursement of physicians' fees under Medicare and report to the Congress no later than January 1, 1973.

75th Percentile

The 75th percentile referred to above (which has already been implemented by regulations) is the level that covers at least 75 percent of the cases. To illustrate, if customary charge for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent rendered by physicians who charge $200, 40 percent rendered by physicians who charge $250, and 5 percent rendered by physicians charging more than $300, the prevailing limit would be $250.

Effective Date

See above.

Purpose

These provisions move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned and follow rather than lead any inflationary trends.

K. Amount of Payments Where Customary Charges Are Less Than Reasonable Cost

Payments for provider services will be the lesser of the reasonable cost of such services or the customary charges for such services. In the case of a public provider of services that makes no charge or only a nominal charge to the public, payment will be on the basis of such items of reasonable cost as the Secretary finds will provide fair compensation.

Effective Date

Accounting periods beginning after December 31, 1972.

Purpose

This provision corrects the situation in which the Medicare program might pay more for services than the provider charges the general public and provides a method of establishing fair reimbursement to no-charge institutions.

L. Limitation on Federal Participation for Capital Expenditure

Reimbursement amounts to providers of health services and health maintenance organizations under the Medicare, Medicaid, and maternal and child health programs for capital costs, such as depreciation and interest, will not be made with respect to large capital expenditures which are inconsistent with State or local health facility plans. States will be required to establish procedures by which a facility or organization proposing a capital expenditure may appeal a decision by a planning agency.

Effective Date

Effective with respect to obligations incurred after December 31, 1972, or earlier if requested by the State. Not applicable to construction towards which $100,000 or more has been spent in the 3 years ending December 17, 1970.

Purpose

It is necessary to assure that Medicare program expenditures are consistent with State and local health facility planning efforts to avoid unnecessary future costs resulting from duplication or irrational growth of health care facilities.

M. Reimbursement Rates for Skilled Nursing Facilities and Intermediate Care Facilities

States will be required to develop methods for reimbursing skilled nursing facilities and intermediate care facilities on a basis reasonably related to cost, and to implement these methods under Medicaid (after approval by the Secretary) by July 1, 1976. These State payment rates for skilled nursing facilities could then be used under Medicare in reimbursing for extended care services. The Medicaid rates could be adjusted upward, but not in excess of 10 percent, to account for specific factors related to Medicare which are not included by the State in the computation of Medicaid rates.

Purpose

This approach avoids substantial auditing and cost-finding expense and provides a means of making equitable adjustments where appropria

N. Certification of Hospitalization for Dental Care

A dentist is authorized to certify the necessity for hospitalization to protect the health of a Medicare patient who is hospitalized for a noncovered dental procedure.

Effective Date

Effective for admissions occurring after the second month following the month of enactment.

Purpose

This provision removes any requirement that a dentist must arrange for a physician to make the necessary certification. The dentist who will perform the procedures should be in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than a physician who may not be familiar with the patient or the nature of the dental procedures to be performed.

O. Optometrist

The term "physician" in title XVIII is expanded to include a doctor of optometry who is authorized to practice optometry by the State in which he provides services.

However, he will be recognized as a "physician" only for attesting to the patient's need for prosthetic lenses, and thus meeting the Medicare requirement of a physician's prescription or order for coverage of such lenses.

Effective Date

This provision is effective only with services performed by an optometrist on or after the date of enactment.

Purpose

This provision is intended to provide the beneficiary with the choice of obtaining prosthetic lenses from an opthamologist or an optometrist.

11300. COVERED SERVICES - SMI

COVERAGE

A. Coverage of Speech Pathology Services Under SMI

Outpatient speech pathology services are covered under SMI on the same basis as outpatient physical therapy services.

Effective Date

This provision is effective January 1, 1973.

Purpose

The purpose of this provision is to make speech pathology on an outpatient basis more generally available.

B. Coverage of Services of Independently Practicing Physical Therapists

Services of a licensed independently practicing physical therapist furnished in his office or the patient's home under a physician's plan and meeting health and safety conditions specified by the Secretary are covered under SMI, but only to the extent of $100 of incurred expenses (subject to the deductible and coinsurance) in a calendar year.

Effective Date

July 1, 1973

Purpose

Some beneficiaries have had to travel to a participating facility to receive covered services, even though the independent physical therapist's office is more accessible. The extension of covered services to the therapist's office or the beneficiary's place of residence is designed to eliminate this anomaly.

C. Coverage of Supplies Related to Colostomies

"Colostomy bags and supplies directly related to colostomy care" are added to the items covered as prosthetic devices under Part B.

Effective Date

Items furnished on or after date of enactment.

Purpose

Colostomy bags and necessary accoutrements required for its attachment has been covered under prior legislation but irrigation equipment and supplies related to ostomy conditions were not

covered. The amendment is intended to broaden coverage to include the various supplies required by the ostomy patient whether or not he uses a bag.

D. Inclusion of Chiropractor Services Under Medicare

Chiropractic services in treating a subluxation of the spine by manual manipulation are covered as physician's services. The subluxation must have been demonstrated by x-ray. The practitioner must be licensed and meet certain minimum educational standards (to be established).

Effective Date

Effective with services provided on or after July 1, 1973.

Purpose

Provides limited coverage for a procedure used by many people as treatment for illness.

E. Experiments in Payment for Durable Medical Equipment

The Secretary is authorized to experiment in various geographic areas with reimbursement approaches that are intended to prevent unreasonable expenses from prolonged rentals of durable medical equipment. He may implement nationally without further legislation any approach found to be workable, desirable, and economical.

Among the approaches to be considered are:

1. Lease-purchase arrangements with suppliers which provide for rental payments to cease when an agreed-upon total for purchase is reached.

2. Lump-sum payment to a supplier when outright purchase would probably be cheaper than rental payments for the estimated period of necessity.

3. Waiver of the 20 percent coinsurance amount if the beneficiary takes used equipment at a price at least 25 percent cheaper than new equipment.

Effective Date

Date of enactment.

Purpose

This provision is intended to find a way to avoid unreasonable program expenditures for rental of equipment. Under existing law rental payments often exceed the purchase price.

F. Outpatient Physical Therapy Services

A hospital or skilled nursing facility (formerly ECF) may provide covered outpatient physical therapy services under SMI to its inpatients who have exhausted their inpatient days, or are otherwise not entitled to HIB.

Effective Date

This provision is effective for services provided on or after the date of enactment.

Purpose

Under this provision it will no longer be necessary to arrange for another provider to furnish the service in order to obtain covered outpatient physical therapy for a provider's own inpatient.

G. Payments for Services of Teaching Physicians

Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless a bona fide private patient relationship had been established or the hospital had, in the 2-year period ending in 1967, and subsequently, customarily charged all patients and collected from at least 50 percent of patients on a fee-for-service basis. Medicare payments would also be authorized on a cost basis for services provided to hospitals by the staff of certain medical schools.

Payments for services donated by volunteer physicians can be made to a fund designated by the physicians if the fund will be used for educational and charitable purposes.

Effective Date

This provision is effective with respect to accounting periods beginning after December 31, 1972.

Purpose

This provision recognized the varied compensation arrangements that exist between physicians and teaching hospitals and attempts to establish reimbursement formulas equitable to both the providers and the program.

DEDUCTIBLES AND COINSURANCE

H. Increase in SMI Deductible

The amount of the SMI deductible is increased from $50 to $60.

Effective Date

This provision is effective for calendar years beginning after 1972; however, for purposes of the carryover provision, the new deductible will be deemed applicable as of 1972 (i.e., any part of the first $60 of covered expenses in 1972 incurred on or after October 1, 1972, will be creditable toward the 1973 deductible).

Purpose

Medical expenses covered under the SMI program have risen considerably since the program began. By raising the deductible amount, beneficiaries would continue to bear a reasonably representative portion of their medical insurance costs.

I. Home Health Services

The coinsurance requirement for covered home health services under SMI is eliminated. The program will pay 100 percent of reasonable cost.

Effective Date

This provision is effective with SMI home health services provided by home health agencies in accounting periods beginning after December 31, 1972.

Purpose

People who receive covered home health care are not responsible for any coinsurance under Part A. However, under prior law those receiving home health care covered under Part B were responsible for a 20 percent coinsurance amount. The amendment eliminates this responsibility, making payment for home health services under Part B the same as under Part A in that respect. In reducing beneficiary liability, the change also reduces any incentive beneficiaries may have had to enter a hospital or ECF in order to qualify for coinsurance-free home health benefits.

11500. GENERAL EXCLUSIONS FROM COVERAGE

A. Relationship Between Medicare and Federal Employees Health Benefits

Effective January 1, 1975, no payment will be made under Medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime the Secretary of Health, Education, and Welfare certifies that such plan or the Federal employees health benefits program has been modified to make available coverage supplementary to Medicare benefits and that Federal employees with Medicare coverage will continue to have the benefit of a contribution toward their health insurance premiums from either the Government or the individual plan equal to the Government contribution for high option FEHB.

Effective Date

January 1, 1975.

Purpose

This provision should assure a better coordinated relationship between the FEHB program and Medicare with the elimination of overlapping coverages, and should assure that Federal employees will receive full value for premiums they pay.